IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

:

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

PLAINTIFFS' BRIEF IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

Highmark callously placed its insured in a medical and economic state of emergency by denying a reasonable request for medically necessary surgery. Highmark attempts to cap its liability to compensate Plaintiffs, within the ambit of ERISA, herein requesting Dismissal of Plaintiff's Count II claim, brought under the PA Bad Faith Statute, which neutrally regulates insurance and permits the Plaintiff to recover punitive damages.

Highmark drafted the terms of Plaintiffs' insurance coverage; including exclusions and consumer costs; and Highmark controls decisions to grant or deny coverage payment to its insured under the contract, which must be narrowly construed in favor of Plaintiffs.

Highmark calculates the risk of loss, when it assesses costs to charge an insured for coverage and Highmark losses, if any, are supplemented by state subsidy and reimbursements. Conversely, insured individuals have no say in the cost for insurance or the bundle of coverage/exclusions and no recourse but personal assets, to pay losses. The duties of insurers and rights of those insured are regulated by federal and state statute. Highmark did not

comply with ERISA regulations in shifting its burden to the protected class of persons, the insureds. The Plaintiffs, whose sons are age fifteen and seventeen, did not have reserve funds to pay for William Scheibler's surgery, which created economic chaos for the family when Highmark denied medical coverage.

JURISDICTION

Congress has divested the state courts of jurisdiction over ERISA claims. Travelers Ins. Co.v. Cuomo, 14 F. 3d 708,714 (1993).(citing ERISA s.502(e)(1), 29 U.S.C. s 1132 (e)(1). NY State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). This is an ERISA controversy over Highmark's denial of coverage to its insured for medically necessary oral surgery in 2004, related to his radiation treatments for cancer, which started in 1997. Plaintiff avers that Highmark denied coverage of his surgery in "bad faith" and seeks to litigate the ERISA and state claims together, to assess the extent and value of Plaintiffs' losses occasioned by Highmark's denial of contractually defined employee benefits. Uncertainty over the implications of the federal statute - s 502(e)(1) of ERISA, 29 U.S.C. s 1132(e)(1) might render the availability of a state court remedy not 'plain.' DeBuono, New York Commissioner of Health, et al v. NYSA-ILA Medical and Clinical Services Fund, U.S. Supreme Court No. 95-1594 (1997). Therefore, Plaintiffs' "Bad Faith" state claim must be litigated and construed *pari materia* with the ERISA claim, in order to render a "plain" remedy Id. within the meaning of the Act. While nothing in ERISA requires employers to establish employee benefit plans, legislative enactment of ERISA was not intended to interfere with state regulation of insurance.

COVERAGE DENIALS TO AN INSURED ARE REGULATED

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. s1001 et seq., was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits. ERISA furthers these aims, in part, by regulating the manner in which plans process benefits claims. Black & Decker Disability Plan v. Kenneth L. Nord, 123 S.Ct. 1965, 2003. ERISA empowers the Secretary of Labor to prescribe such regulations as he finds necessary or appropriate to carry out the statutory provisions securing employee benefit rights. 29 U.S.C.S s1133, 1135. Plans must provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant. 29 U.S.C.S s1133(1). ERISA further requires that plan procedures afford a reasonable opportunity for a full and fair review of dispositions adverse to the claimant. 29 U.S.C.S s1133(2). ERISA's regulatory framework presumes "good faith" that must be strictly construed, as contractually defined benefits constitute a property right relied upon in employees and their beneficiaries. Congress provided a savings clause that exempts state laws that "regulate insurance" from ERISA preemption. 29 U.S.C. s 1444(a). The third circuit held that 42 Pa. CSA s8371 regulates insurance but that it does not affect the risk pooling arrangement between insurer and insured, under materially different facts and consequences from those alleged before this court, by the Scheibler Plaintiffs.

RISK POOLING ARRANGEMENTS

Under ERISA enforcement remedies, insurers hold onto funds in dispute until judgment is rendered, at little or no additional cost. Under 42 Pa. CSA s 8371 enforcement remedies, risk pooling arrangements between parties are

affected by awarding punitive damages against bad faith insurers: "[i]n an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured..." The remedies available under s8371 are awarded or assessed against the insurer." Id. If a Plaintiff alleges that an insurer acted in bad faith, adversely affecting the insured and the insurers' alleged bad faith constitutes a substantial affect on the risk pooling arrangement between the parties, the claim meets the second prong of the Miller test, saving the claim from preemption. The Plaintiffs here allege that Defendant insurer denied his claim in bad faith and benefited in a way that substantially affects risk pooling, utilizing state subsidy.

In Miller, Justice Scalia considered a scenario whereby Kentucky's Any Willing Provider Law regulates the conduct of insurance providers with regard to third-party providers. Miller 123 S.Ct. at 1477. In doing so, Justice Scalia concludes that the law "regulates insurance by imposing conditions on the right to engage in the business of insurance." Kentucky Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003). The Third Circuit held that 42 Pa. CSA s8371 satisfies the first prong of the Miller test as it imposes industry-wide conditions regulating insurer's conduct in the normal operation of the business of insurance. Barber v. Unum Life Ins. Co. of America, 383 F. 3d 134 (3rd Cir. 2004). The third circuit, in Barber did not find a substantial affect to the risk pooling arrangements between the parties, to satisfy the second prong of the Miller test, where the insurer rescinded disability benefits under a group, long term disability policy, purchased by the employer. Not stated, whether disability is work related.

Labor laws hold employers responsible to compensate disabled employees for work related injuries if employer's insurer denies coverage. Employers cannot evade liability for being uninsured/underinsured or when its insurer denies

disability coverage. However, employers are not bound by preemption from litigating bad faith insurance violations in state court. In Barber, preemption held the parties to an insurance contract where the employer is the insured and plaintiff was a beneficiary.

The savings clause is an exception protecting state laws from exemption which regulate insurance, banking and securities. Medical insurance, like securities, involves an administrator or fiduciary who has discretionary authority to determine eligibility for benefits or to construe the plans terms. The third circuit has held that "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." Pinto v. Reliance Standard Life Ins. Co., 214 F 3d 377, 378 (3d Cir. 2000). Plaintiff alleges that Highmark realized a benefit by denying coverage to its insured, accepting Plaintiff's reduced payment for the surgery, and accepting full state reimbursement for the services. However, the insured Scheiblers had no reserve to pay for William Scheibler's surgery. Therefore, Highmark's denial of coverage has occasioned serious losses to its insured.

The insurer/insured relationship between Scheiblers and Highmark is materially distinguished from the insurance relationship of the parties in Barber. Therefore, preemption by court dismissal, here, shifts the burden of loss from insurer to its insured, the class of persons expressly protected.

There is one set of operative facts to litigate and common identity of protected persons, which merit *pari materia* litigation and construction of the law, ERISA and Department of Labor regulations with state insurance law.

EXPRESS PREEMPTION

State regulation of insurance is expressly exempt from preemption by the ERISA Savings Clause, where it *affects* the risk pooling arrangement between the insurer and insured. Kentucky Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003). The court must conduct a two part test pursuant to the "Miller Test", with s 8371 satisfying both prongs in order to be saved from preemption. Stone v. Disability Management Services, Inc., 31 EBC 1741 (October 14, 2003). The "Miller Test" has been applied to 42 Pa. CSA s 8371 in Stone, where the court held that the Bad Faith statute is "saved" from ERISA preemption in that the law is directed toward the insurance industry and clearly affects allocation of risk between insurer and insured in that the law provides for possibility of punitive damages. Id. Highmark, in its capacity as an insurer, is subject to Pennsylvania regulatory enforcement here. Therefore, Plaintiff's bad faith state claim must be litigated under federal jurisdiction, to assess damages in concert with ERISA, in order to render a "plain" remedy within the meaning of the state Act.DeBuono, New York Commissioner of Health, et al v. NYSA-ILA Medical and Clinical Services Fund, U.S. Supreme Court No. 95-1594 (1997). As applied here, preemption may wrongfully bar Plaintiffs' due process on the 'bad faith insurer' state claim.

CONFLICT PREEMPTION

The "any law of any State" language in the savings clause clearly indicates Congress purpose to respect state sovereignty. As applied here to Defendant, Highmark, a medical coverage insurer, Section 8371's provision of punitive damages is consistent with Congress' intent in drafting ERISA. Stone at 1748. In its footnote #3, the district court in Stone reversed its prior ruling on the issue of conflict preemption: In making this determination, we acknowledge that this Court had previously determined that Section 8371 was subject to conflict preemption. However, in light of

Miller and the persuasive reasoning put forth by Judge Newcomer in Rosenbaum, we exercise our judicial discretion to reconsider this issue. Stone at 1748.

CONCLUSION

Highmark did not process Plaintiffs' claim for benefits according to the Department of Labor regulations. Congress did not intend ERISA to preempt state laws which regulate and sanction insurers who realize an economic benefit from wrongful denial of coverage. If Plaintiffs allegations are accepted as true and all reasonable inferences drawn therein: 1) Highmark did not provide Plaintiffs adequate notice in writing, setting forth the specific reasons for its denial in a manner calculated to be understood by the participant. 2) Highmark provided Plaintiffs no opportunity for full and fair review of its adverse decision, short of filing a Complaint in federal court. And,
3) Highmark realized an economic benefit by seeking full reimbursement for Plaintiffs surgery. Highmark's failure to adhere to ERISA regulations combined with the prospect that Highmark realized an economic benefit from its decision to wrongfully deny coverage to its insured raises a material question of fact. There is legal authority that Section 8371 is saved from preemption. Plaintiff's cause of action can be distinguished from Barber v. Unum, based on differences of material fact concerning allocation of losses.

WHEREAS, Plaintiff, William Scheibler's medical condition requires ERISA civil enforcement in the immediate future and delay burdens the entire family. Plaintiff respectfully petitions this honorable court to issue an order denying Defendant's Motion to Dismiss Plaintiffs' Count II 'bad faith insurer' state claim.

Respectfully submitted,

January 28, 2004

Mary Ellen Chajkowski, Esq.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

Plaintiffs' Petition for Reconsideration

AND NOW, come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Petition the district court to Reconsider its February 1, 2005 *Memorandum* Opinion and Order granting Defendant's Motion to Dismiss the Plaintiffs' Complaint, with prejudice. Plaintiffs aver the following, in support of the court's Reconsideration:

1. The district court's dismissal of Count II, with prejudice, cut off the Plaintiff's right to a full and fair review of defendant's denial of medical insurance coverage.

2. Whether the Plaintiffs' Highmark medical insurance is part of a qualified plan is a material question of fact, precluding dismissal of Plaintiff's bad faith insurance claim, where coverage and exclusions are not specific.

3. In response to a written request for a copy of the plan, Highmark sent a copy of an August 2003 "draft" that was never approved (R.1a, 12a).

4. Highmark's letter dated May 17, 2004 (Exhibit **A**) cited its medical policy D-6 as its basis for denial yet sent its medical policy D-5 (R.1a, 10a, 11a) a collateral document (November 2003) to the plan "draft" (R.13a).

5. Highmark's letter (Ex.A), stating that an Appeals Commmittee reviewed Plaintiff's request for reimbursement, is not supported by its Outsource Report (R.7a, 8a, 9a) on 4/21/04 – "use denial letter W1-M" (R.9a); and (R.8a) "Please complete review by 5/14, and do not send letter. Thanks." The 05/14/04 Physician reviewer Report is unsigned and refers to #D-6.

6. Highmark's reviewer misspelled/questioned "(?*osteonecrosis*)" (R.9a), a basic medical term *osteoradionecrosis* (Exhibit **B**) that distinguishes bone death caused by radiation injury from infection of compromised bone.

7. William Scheibler's treating physicians attributed his bone loss and the medical need for surgery to his radiation treatments (R.3a, 4a,5a,6a).

8. The district court failed to incorporate plaintiffs' legal arguments distinguishing the Third Circuit application of law in Barber v. Unum Life Ins. Co. of America, 383 F.3d 134 (3d Cir. 2004) from the proposed application of law to the facts *sub judice*, including the materially different risk pooling arrangement between insurer and insured.

9. Whether addressed a group, long-term disability insurance policy, purchased by the employer, a contract with specific coverage/exclusion language.

10. Whether the Highmark "draft" plan controls; and whether the "draft" plan offered procedures that afford a reasonable opportunity for a full and fair review of dispositions adverse to claimants 29 U.S.C.S. s1132(2) is a material question of fact, that precludes dismissal with prejudice.

WHEREFORE, Plaintiffs allege facts to support a finding that two material issues of fact preclude dismissal with prejudice:

1) Whether the "draft" plan is qualified; and

If it is qualified,

2) Whether the plan offers procedures that afford a reasonable opportunity for full and fair review of dispositions adverse to claimants.

And Plaintiffs Petition the district court to Reconsider and Vacate its February 1, 2005 Order that Plaintiffs' Count II be dismissed with prejudice.

Respectfully submitted,

/s/Mary Ellen Chajkowski, Esq.
Attorney for Plaintiffs

February 10, 2005

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

PLAINTIFFS' REPLY TO DEFENDANT'S ANSWER AND AFFIRMATIVE DEFENSES

AND NOW come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Reply to Defendant, Highmark, Answers to Plaintiffs' Complaint. Highmark Answers raise material fact questions (MFQ), which preclude dismissal:

Highmark lists as its "**First Defense**" - Answer to Plaintiffs' Complaint:

1. Object. MFQ: Whether Highmark is denying Plaintiffs' ERISA claim in addition to its first motion to deny Plaintiffs' state law claim?

5. Object. Plaintiffs' are not privy to any contract between Highmark and the employer and Highmark did not attach a copy of the contract referred to in its Answer.

6. Object. MFQ: On what basis does Highmark deny Plaintiffs' allegation that Highmark is an employee benefits plan insurer?

7. Object. MFQ: Highmark's denial is contradicted by its May 17, 2004 letter to Plaintiff (Petition for Reconsideration), which states Plaintiffs' ERISA rights.

8. Object. Highmark insured and paid for William Scheibler's 1997 and subsequent treatments and, as such, has access to those payment records, which needed to be fully considered with William Scheibler's medical letters of appeal.

9. Object.

10. Object.

11. Object.

13. Object. MFQ: Highmark referred to D-6 plan language and provided the D-5 language, when requested by counsel, a collateral document to the plan booklet.

14. Object. The letter from Plaintiffs' Counsel was sent to Highmark on June 1, 2004 (Exhibit **A**) and acknowledged by Highmark on June 9, 2004 (Exhibit **B**). MFQ: Whether laches and statute of limitations are "good faith" affirmative defenses proferred by Highmark?

15. Object. MFQ: Whether Highmark accepted reimbursement for the same?

16. Object. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

17. Object. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

18 Object. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Count I
ERISA

21. Object. MFQ: Whether Highmark is permitted to deny that express ERISA language applies to Plaintiffs' ERISA Claim when Highmark's May 17, 2004 letter of denial informs Plaintiffs of their right to appeal it under ERISA?

23. Object.

24. Object. Plaintiffs demand an offer of proof.

Count II
PA Bad Faith Statute, 42 Pa. C.S. s8371

26. Object. MFQ: Whether Highmark Answers denying ERISA liability make Highmark subject to the insurance Bad Faith Statute in federal court, as the ERISA claim must first be considered under exclusive federal jurisdiction?.

27. Object. Non-responsive Answer.

Second Defense

28. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Third Defense

29. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Fourth Defense

30. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Fifth Defense

31. Object as disputed. [See Plaintiff's Petition for Reconsideration for explanation for documents presented in the Complaint.] Upon Reconsideration of Dismissal, these facts, and all reasonable inferences, must be construed in favor of Plaintiffs, Donna Scheibler and William Scheibler.

"Ninth" Defense

32. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Tenth Defense

33. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences must be construed in favor of the Plaintiffs.

Eleventh Defense

34. Object, as affirmative defenses not raised in Highmark's first pleading were waived procedurally. If not waived, the laches affirmative defense has no factual basis.

Twelfth Defense

35. Object, as affirmative defenses not raised in Highmark's first pleading were waived procedurally. If not waived, the statute of limitations defense is not supported by factual basis nor legal authority.

MFQ: Whether laches and statute of limitations are good faith affirmative defenses where Plaintiffs' Petition for Reconsideration raises Defendant Highmark's inadequate appeal procedure as a material fact question?

WHEREFORE, Plaintiffs, Donna Scheibler and William Scheibler, submit this Reply to Defendant's Answers to the Complaint and again Petition the district court to Reconsider and Vacate its February 1, 2005 dismissal with prejudice.

WHEREAS, Plaintiffs petition this honorable court to enter an order on the Petition for Reconsideration prior to Plaintiffs' thirty (30) day deadline to submit a Notice of Appeal. All of Plaintiffs' factual allegations, and reasonable inferences that may be drawn from them, including any responses or lack thereof, must be construed in favor of the Plaintiffs, Donna Scheibler and William Scheibler.

Respectfully submitted,

/s/ Mary Ellen Chajkowski, Esquire

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

PLAINTIFFS' REPLY TO DEFENDANT'S BRIEF IN OPPOSITION TO PLAINTIFFS' PETITION FOR RECONSIDERATION

AND NOW come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Reply to Defendant, Highmark's Brief in Opposition to Plaintiffs' Petition for Reconsideration:

1. Plaintiffs ask the district court to fully consider the fact that Defendant chose not to respond to every fact in the Petition for Reconsideration, which must be construed in favor of Plaintiffs.

2. ERISA regulations were not adhered to by Defendant, therefore Highmark does not seek the protective ambit of ERISA as a clean hands insurer.

3. Substantively, absent an adequate appeal procedure that is understood by the participants, Plaintiffs' only recourse for due process in claims against the Defendant is with the courts and federal courts have a constitutional role in ERISA enforcement.

4. There is one operative set of facts between Plaintiffs' claims, which makes them pendant claims that must be litigated together.

5. Congress reserved exclusive jurisdiction of ERISA with the federal court, which necessitates that both claims be tried together in federal court.

6. There is no automatic ERISA pre-emption for claims regarding insurance, banking and securities, pursuant to the savings clause.

7. There are factual allegations and legal arguments raised by the Plaintiffs' to warrant jurisdiction based on the risk allocation prong of Miller that were not present in the third circuit consideration of Barber, which Defendant did not address in its brief. Nor did Defendant address risk allocation in any other pleading.

8. Plaintiffs, as insureds, are members of the ERISA protected class.

9. Defendant admits that this court's February 1, 2005 dismissal is vague. See Highmark's Brief, page 2, footnote 1, which states:

"Highmark is unclear how these allegations are implicated by the court's dismissal of Count II based upon ERISA pre-emption doctrines, and how they might be considered in order to effect a reconsideration of the Court's decision."

10. Plaintiffs constitutional right to due process takes legal precedence over pre-emption "doctrines" and Plaintiffs are prejudiced by this dismissal.

WHEREFORE, Plaintiffs, Donna Scheibler and William Scheibler, submit this Reply to Defendant's Brief in Opposition to Plaintiffs' Petition for Reconsideration; and again Petition the district court to Reconsider and Vacate its dismissal with prejudice.

WHEREAS, Plaintiffs petition this honorable court to enter an order on the Petition for Reconsideration prior to Plaintiffs' thirty (30) day deadline to submit a Notice of Appeal.

WHEREFORE, All of Plaintiffs' factual allegations, and reasonable inferences that may be drawn from them, including any responses or lack thereof, must be construed in favor of the Plaintiffs, Donna Scheibler and William Scheibler.

Respectfully submitted,

Mary Ellen Chajkowski
Attorney for the Plaintiffs

February 23, 2005

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

PETITION FOR EXTENSION OF TIME TO APPEAL

AND NOW, come the Plaintiffs, by and through their attorney, Mary Ellen Chajkowski, Esquire to Petition this honorable court for Permission To Appeal the February 1, 2005 Order of the district court, entered on February 2, 2005, granting Defendants' Motion to Dismiss Count II of Plaintiffs' Complaint, with prejudice. Plaintiffs aver the following in support of this Petition:

1. Defendant Highmark's medical insurance was selected as one of several plans offered by Plaintiff Donna Scheibler's employer.

2. Plaintiffs filed a Complaint to appeal Defendant's denial of medical coverage, Count I an ERISA violation and Count II a Bad Faith Insurance Claim, pendent claims with one set of operative facts which must be tried together, as Congress has reserved exclusive federal jurisdiction over ERISA claims.

3. Defendants attempt to avoid punitive damages based on ERISA; while Defendants' Answer to Appellants' Complaint disputes Defendants' ERISA liability in Defendants' Answers to Complaint paragraphs # 1, 6, 7, and 21.

4. Defendants Motion to Dismiss Count II created an ambiguity as Count I may be interlocutory, despite Defendants express intent to deny ERISA liability.

5. Plaintiffs petition this honorable court for an Extension of Time to Appeal the district court's dismissal of Count II in order in to preserve their appellate rights.

WHEREAS, Plaintiffs have shown cause to request an Extension of Time to Appeal and request the court's full consideration of this Petition.

Respectfully submitted,

Mary Ellen Chajkowski, Esquire

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,

Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,

Defendant(s).

SUGGESTION OF DEATH UPON THE RECORD
Under Rule 25 (a)

AND NOW comes Plaintiff Donna Scheibler, by and through her attorney Mary Ellen Chajkowski, Esquire, to suggest upon the record, pursuant to Rule 25(a), the death of Plaintiff William Scheibler, her husband, during the pendency of this action.

This action shall proceed in favor of Donna Scheibler and against Highmark.

Respectfully submitted,

/s/Mary Ellen Chajkowski

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

Petition for An Extension of Time to Amend Complaint

AND NOW, come the Plaintiffs, by and through their attorney, Mary Ellen Chajkowski, Esquire, to Petition this honorable court to grant their request for an extension of time to amend the Complaint:

1. Defendant filed a Motion to Dismiss Count II, Plaintiffs' claim for punitive damages occasioned by Defendant's Bad Faith denial of medical insurance coverage, pursuant to state law 42 Pa. C.S. s8371, which the district court granted.

2. Plaintiff requested permission to amend the complaint on March 10, 2005, which the court granted.

3. Plaintiff filed a notice of appeal before the Third Circuit on the dismissal, which is pending *en banc* consideration; therefore, Plaintiff hereby requests a reasonable extension of time to amend the Complaint.

WHEREAS, Plaintiff requests a reasonable extension of time to amend the Complaint, requesting thirty days after the pending appeal is concluded.

Respectfully submitted,
Mary Ellen Chajkowski, Esquire

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.
HIGHMARK BLUE SHIELD,
Defendant(s).

PLAINTIFFS' PETITION FOR RECONSIDERATION
Of the April 13, 2005 Court Order
Denying Plaintiff's Petition to Amend Complaint

AND NOW come the Plaintiffs, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Petition for Reconsideration of the April 13, 2005 district court order denying Plaintiffs' petition for an extension of time to Amend:

The Parties

For more than twelve years, Plaintiffs have been Blue Cross /Blue Shield (BC/BS) insureds, through Keystone and/or Defendant Highmark, which have merged. The family was insured through William Scheibler's ABB employment until disability; which he continued for two years. During that time, plaintiffs were insured by two BC/BS policies; through William's ABB employer and Donna's Sony employer. When Donna accepted employment with ABB, she selected Highmark at a premium cost in order to maintain continuous BC/BS medical coverage for her family. Plaintiffs have two sons, age fifteen and seventeen. Plaintiff Donna Scheibler is an ABB factory employee, the position William held prior to his disability.

January 2004, Plaintiff William Scheibler was cancer free for more than five years. Though disfigured by neck surgery, William participated in everyday life; he drove to church, his sons games and school functions.

January 19, 2004 (Exhibit **A**), William's physician wrote a letter requesting preauthorization for medically necessary oral surgery, including pre-op and post-op hyperbaric treatments to assist healing which Defendant acknowledges receiving (R.).
As months passed, William's teeth started to fall out one by one; pain and depression increased, causing him to withdraw. Plaintiff Donna Scheibler worked full time and raised two sons during the years that her husband battled various health problems but experienced a great deal of duress over Highmark's failure to acknowledge the medical advice of treating physicians (R. 2a). These events created stress among family members, for which they sought therapy. William was prescribed medication, for pain and depression, and experienced dramatic weight loss as mouth pain made it difficult to eat

While awaiting an insurance decision, the parties learned that William's mother was diagnosed with cancer, creating more duress, as it followed the recent death of his father. William was frustrated by Defendant's delay and lack of communication. William made calls to Defendant (Exhibit **E**) and wrote letters to elected congressional representatives (Exhibits **B, C, D**). Defendant's material representations to the written inquiry of the congressional representatives are not supported by record evidence.

Plaintiffs refinanced their home to pay for surgery and related expenses pending appeals to Defendant. Although the parties originally had mortgage insurance, they did not qualify in 2004 based on William's medical condition. The plaintiffs (age 45) were placed in a position,

for the first time in their lives, to accept help from their church.

Defendant, Highmark, whose merger with Pennsylvania's Blue Cross/Blue Shield created an entity with 2.8 million subscribers. Defendant Highmark accepts state subsidy. In 2004, Defendant Highmark reported the following information to the public:

2004 Highmark reported that it held over two billion dollars in reserve,

2004 Highmark reported over 300 million dollars in profit, and

2004 Highmark reported one billion dollars in revenue to its dental subsidiary.

Defendant Highmark did not Answer the Complaint within 20 days as ordered, when accepting service. Highmark filed no corporate disclosure with the district court and an incomplete corporate disclosure with the appeal court. Highmark's May 17, 2004 (R. 34b) and May 21, 2004 (Exhibit **E**) letters contain no return address and direct Plaintiffs to the same 800 phone number to make inquiries. In its pleadings, Highmark admits certain payments of pre-op and post-op treatments but deny making the decision denying coverage for surgery, without identifying what entity makes coverage decisions.

Correspondence to Plaintiffs contained double entity names on the letterhead: Highmark Blue Cross/Blue Shield and Keystone Health Plan West A Highmark Company. [Again no return address and forwarding further inquiry to a different 800 phone number].

Referencing that information with information provided to Plaintiffs Congressional representatives and the Defendant's vague and sometimes contradictory responses in the pleadings, the issue of "standing" is ambiguous.

March 3, 2005 the parties were Ordered to Appear for Oral Argument re: Petition for Reconsideration (R. 72b). March 10, 2005 statements by the district court (R. 92b) were Plaintiffs' first Notice that its due process on Defendant's conflicting responses in the pleadings were no longer at issue and Plaintiffs' counsel requested permission to amend the Complaint, which the court granted. April 8, 2005, Plaintiff filed a Petition for an Extension of Time to Amend, which the district court denied.

The Plaintiffs aver the following to support the district court's Reconsideration:

1. Plaintiff was first notified that Defendant intended to change its position that it is NOT an ERISA insurer on March 10, 2005 (R. 93b), when the parties appeared before the court, as Ordered, for "Oral Argument re: Motion for Reconsideration (R. 72b).

2. The March 10, 2005 statements by the district court, about its application of
due process and material facts (R. 94b); and its *sua sponte* acceptance of Highmark's status as an ERISA Defendant (R. 93b), are presently under appeal pursuant to Plaintiff's Petition for *en banc* consideration. Due process cannot be waived by courts on any level.

3. Plaintiff's substantive right to due process; barred by Defendant's failure to adhere to ERISA Department of Labor Regulations (R. 21b - Black & Decker) and the district court's application of the Barber case to the facts alleged *sub judice,* will create a constitutional conflict in federal circuit courts, if upheld.

> "Although in general federal courts must give the same effect to state court judgment that

> would be given by court of state in which judgment was rendered, an exception exists for state court rulings made in absence of . . . due process, in which case federal court may declare state court's judgment void ab initio and refuse to give it effect in federal proceeding."
>
> Twin City Fire Insurance Co. v. Adkins, 2005 WL 486670 (6th Cir. 2005).

The Sixth Circuit in Adkins went on to cite World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286 (U.S. 1980), where it held that "a judgment rendered in violation of due process is void in the rendering State and is not entitled to full faith and credit elsewhere." Woodson at 291, quoted in Adkins, 2005 WL 486670 at 5. For the district court to not grant a reasonable extension to Amend appears to violate due process.

4. The district court must fully consider the fact that Defendant chose not to respond to material allegations, which must be construed in favor of Plaintiffs.

5. ERISA notice and appeal regulations were not adhered to by Defendant. Absent "plan" due process that is understood by the participants, Plaintiffs' due process on denial of their medical insurance claim, and the harms it occasioned, is with the courts.

6. The savings clause exception to ERISA pre-emption, for claims regarding insurance, banking and securities, must be strictly construed in favor of insureds, where the district court acknowledges plaintiff's allegation that an insurer defendant may have realized an economic gain at the insured's expense (R.27b).

7. The district court's February 1, 2005 order (R. 29b) acknowledged Plainitffs' Response in Opposition and Motion to Deny - Defendant's Motion to Dismiss, filed January 28, 2005, that included factual allegations and legal argument Defendant is a fiduciary decision making insurer as described in Pinto v. Reliancer Standard Life Ins. Co., 214 F. 3d 377,378 (3d Cir. 2000), where the third circuit held that "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review. Id. The Pinto standard of review is more stringent that applied by a panel of the appellate court in Barber. However, Plaintiffs' legal arguments were not incorporated in its Opinion (R. 26b), which the district court entered before Defendant's ten-day Response period (R. 13b) had elapsed.

8. Defendant Highmark, in its Answer and Affirmative Defenses, identifies itself as an insurer in contract with employer (R. 44b, #5), but fails to attach a copy of said contract and Defendant denies that it is a benefits plan insurer (R. 45b, #6).

9. If Defendant's contract were an arms length transaction and Defendant intended to evade liability to Plaintiffs, it has a legal right to join an additional defendant, which Highmark did not do.

10. Defendant admitted receipt of a January 19, 2004 letter (Exhibit **A**) from Plaintiff's physician, Dr. Rendulich, DDS, requesting authorization for payment of pre-op and post-op treatments and the cost of medically necessary surgery (R. 45b, # 9); admits approving payment for hyperbaric oxygen treatments (R. 45b, #10); but filed a non-responsive and confusing Answer to plaintiffs' Complaint allegation #11, that "Defendant Highmark denied payment for the scheduled surgery".

11. Plaintiffs' cause of action has been inequitably handicapped and prejudiced by a series of material *sua sponte* court actions and omissions; including, *inter alia,* the following:

A) 12/23/04 Complaint filed; *no enforcement of Rule 26 disclosures* ***to date***.

B) 01/03/05 Defendant accepted service, ordered to Answer within 20 days.

C) 01/13/05 Defendant filed a Motion to Dismiss by ERISA Preemption.

D) 01/14/05 district court *Ordered the parties to submit to its Motions rules*.

E) 01/28/05 Plaintiffs filed Opposition in Response and Motion to Deny.

F) 02/01/05 district court *granted Dismissal before response time lapsed*.

G) 02/11/05 Plaintiff filed Petition for Reconsideration and to Vacate.

H) 02/15/05 district court *Ordered Defendant to respond by 02/24/05.*

I) 02/16/05 Defendant filed Answer and denied that it is an ERISA insurer.

J) 02/23/05 Defendant filed non-responsive Brief Opposing Reconsideration.

K) 02/23/05 Plaintiff filed Reply to Answer and Affirmative Defenses.

L) 02/28/05 Plaintiff filed Reply raising Defendant's non-responsiveness.

M) 03/01/05 court *Ordered the parties to appear for Oral Argument 03/10/05.*

N) 03/03/05 Plaintiff filed for an Extension of time to Appeal.

O) 3/08/05 court entered Order *denying* ***uncontested*** *request for extension.*

P 03/08/05 Plaintiff filed a Notice of Appeal.

Q) 03/10/05 The parties *appeared before the court 4:25 to 4:40 pm* (R. 84b).

R) The court granted Plaintiff's request to Amend within 30 days.

S) 03/11/05 court *entered Order denying Petition to Vacate 02/01/05 Order*.

T) 04/08/05 Plaintiff filed Petition for Extension of Time to Amend.

U) 04/13/05 *court entered Order denying **uncontested** request for extension*.

The district court inequitably denied uncontested motions (O, U) and expanded Defendant's response period (F, H, M), pursuant to its order (D). The record, including failure to enforce rule 26, creates an inference that Defendant lacks "standing" to litigate.

12. Defendant denied Complaint allegation #13, that "Defendant relied upon unspecified plan language to deny coverage" without clarification to support two pages improperly referenced (R. 10a-11a) in its May 14, 2004 letter to Plaintiff.

13. Highmark's unsigned letter (Exhibit **G**) denies coverage for "Office Surgical" extractions, which may not be eligible for state subsidy, a material fact which explains Highmark's failure to respond to Plaintiffs' allegation that Defendant profited.

14. Record pleadings and the transcript (R.87b-89b) created material questions of fact, precluding Dismissal (R. 57b-62b; R. 67b-69b), which the district court did not incorporate in its Order March 10, 2005 (R. 83b).

15. The record pleadings reflect ambiguity about Defendant's "standing" in this litigation; a material jurisdictional issue that can be raised at any time.

16. Defendant materially misrepresented the effective date of coverage and its appeal process (Exhibit **F** in written statements made to Plaintiff's elected congressional representatives, who made written inquiries on Plaintiff's behalf (Exhibits **B, C, D**).

17. Defendant's non-responsive Answer to paragraph 14 of the Complaint is refuted by a copy of Plaintiff's June 1, 2004 letter (R. 63b),acknowledged by its reply (R. 64b).

18. Defendant's request, from Plaintiffs' Counsel, for a "HIPPA compliance" authorization did not yield a single medical record (R. 1a-84a), which indicates that Defendant insurer never considered Plaintiffs medical records in its decision to deny coverage of Plaintiff's medically necessary surgery in January 2004.

19. No medical records were incorporated by Defendant's Expert (R. 7a).

WHEREFORE, All of Plaintiffs' factual allegations, and reasonable inferences that may be drawn from them, including any responses or lack thereof, must be construed in favor of the Plaintiffs, Donna Scheibler and William Scheibler.

WHEREAS, the record, including failure to enforce rule 26, creates an inference that Defendant lacks "standing" to litigate. Plaintiffs reasonably request that the district court 1) permit Defendant to respond to the allegations in this Petition; 2) that it Order Defendant to produce a copy of the contract with Plaintiffs' employer referred to in its pleading (R. 45b); 3) that it equitably enforce FRCP 26, so that Plaintiff may identify the correct parties and causes of action; and that 4) it grant a Plaintiff a reasonable extension of time to produce a deposition of Defendant's reviewing

committee, including its expert, Dr. John Boggiano, Oral and Maxillary Surgeon (R. 1a), and 5) to grant an Extension of Time to Amend the Complaint.

Respectfully submitted,

/s/Mary Ellen Chajkowski, Esquire

April 22, 2005 ***Attorney for the Plaintiffs***

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 05-1717 & 05-2527

DONNA SCHEIBLER and :
WILLIAM SCHEIBLER, her husband, :
Appellant(s),

v.

HIGHMARK BLUE SHIELD,
Respondent(s).

APPELLANTS' JURISDICTIONAL STATEMENT
MOTION FOR INTERLOCUTORY APPEAL

AND NOW, come the Appellants, by and through their attorney, Mary Ellen Chajkowski, Esquire to file this Jurisdictional Statement, as the federal law applies to the facts at issue before this Appellate Court, and to move this court for interlocutory appeal:

1. Appellants, as "plan insured" members of the protected class of persons, within the express language of ERISA and Pennsylvania's bad faith insurance regulatory statute at 42 Pa. C.S. Section 8371, filed a Complaint which alleged that Appellee Insurer's denial of coverage constituted a violation of the federal and state statutes and Appellant's substantive right to due process, which requires *strict scrutiny* appellate review.

2. Appellant Donna Scheibler chose Appellee's insurance coverage, from several health plans offered by her employer, and Appellant pays part of the cost for coverage.

3. Appellee, a state subsidized Blue Shield insurer, provided coverage to William Scheibler through his employment for more than ten years and prior to disability.

4. Medical insurance, like securities, involves an administrator or fiduciary who has discretionary authority to determine eligibility for benefits or to construe the plans terms. This Appeal Court has held that "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." Pinto v.Reliance Standard Life Ins. Co., 214 F 3d 377, 378 (3d Cir. 2000).

5. Appellee did not deny Appellant's Complaint allegation that Appellee realized a benefit denying coverage to its insured, accepting Plaintiff's reduced payment for the surgery, and accepting state reimbursement for the services.

6. Appellant herein seeks *en banc* appellate review of its panel decision preempting Pennsylvania's bad faith law at 42 Pa. C.S. Sec. 8371, in Barber v. Unum Life , 383 F.3d 134 (3d Cir. 2004), which may have erred in extending preemption of a dissimilar state law in Kentucky Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003) to Pennsylvania's bad faith insurance law.

7. Barber v. Unum Life , 383 F.3d 134 (3d Cir. 2004) an interlocutory appeal under 28 U.S.C. section 1292(b), decided by a panel of this appellate court, inequitably and adversely preempts "plan insureds" only from civil enforcement of the "bad faith" law.

8. The appeals before this court are of great public importance to all third circuit healthcare coverage "plan insureds"; "plan administrators"; and healthcare providers, which merits *en banc* appellate review.

9. Appellants' substantive right to due process warrants this appellate court's exercise of *en banc* jurisdiction to hear an interlocutory appeal, under 28 U.S.C. section 1292(b), as a recent decision by a panel of the Third Circuit may bind district courts to preempt a neutral state law intended to regulate and sanction an insurer's "bad faith" failure to process insurance claims Barber v. Unum Life , 383 F.3d 134 (3d Cir. 2004).

10. Appellant's federal protection here includes the Department of Labor Regulations, requiring notice, specificity in denial, and a written appeal procedure, in order to qualify Appellee to first establish "ERISA standing" before filing its motion to dismiss Appellant's "bad faith" insurance claim which did not happen here.

11. A federal appeals court, in Twin City Fire Insurance Co. v. Adkins, 2005 WL 486670 (6th Cir. 2005), cited World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286 (U.S. 1980), where it held that "a judgment rendered in violation of due process is void in the rendering State and is not entitled to full faith and credit elsewhere." Woodson 291.

12. Appellant's right to due process takes precedence over requirements that an Order be certified, within the meaning of 28 U.S,C. 1291; and warrants an interlocutory appeal, under 28 U.S.C. 1292(b), as a panel of this appeal court did in Barber.

13. Appellant's appeal under 05-1717 petitions the district court to note the ambiguity regarding Appellee's standing, and the court's jurisdiction, where Appellee:

A) Filed a motion for dismissal based on ERISA preemption;

B) Then denied being an ERISA insurer in its Answer filed after dismissal;

C) Admitted making certain payments on behalf of its insured but denied that it made the decisions in refusing certain other payments, including surgery.

14. The ambiguity surrounding Appellee's standing and the court's subject matter jurisdiction were created by the failure to enforce Rule 26 prior to dismissal.

15. Appellant's appeal under 05-2527 is a collateral order, denying Appellant's petition to extend its March 10, 2005 approval to Amend, pending this court's decision on Appellant's 05-1717 appeal of the district court's dismissal of the bad faith claim.

16. The Pennsylvania rules of Appellate Procedure would permit Appellants' appeals:

A) Pursuant to Pa. R.A.P. 312, permit an interlocutory appeal by permission; B) Collateral Orders, pursuant to Pa. R.A.P. 313(a), are permitted;

C) Collateral is defined in 313(b) …where the right involved is too important to be denied review and the question presented is such that if review is

postponed until final judgment in the case, the claim will be irreparably lost.

17. Preemption of the state "bad faith" statute effectively denies Appellant the right to recover punitive damages, an inequitable application of law where similarly situated insureds, if not participating in a "plan", are not preempted by ERISA.

18. Pursuant to federal rule of procedure 54(b), Judgment upon multiple claims,

"When more than one claim for relief is presented in an action, …the court **may** direct the entry of a final

judgment as to one or more but fewer than all the claims only upon an express direction for the entry of judgment.

Appellees made no record demand for judgment here.

19. Appellants' petition for an interlocutory appeal creates no prejudice to Appellee.

20. There is no preclusion on appealed Orders that have not been litigated.

21. It may be a waste of judicial resources to try a case before a jury when Appellants have already declared they will ultimately appeal the "bad faith" insurance preemption.

22. There is no evidence to support a denial of Appellant's petition to Amend.

23. Subject matter jurisdiction is ambiguous, pending Rule 26 disclosures here.

24. The statutory violations at issue are subject to strict scrutiny.

WHEREAS, Appellants hereby move this court to grant an interlocutory appeal on Orders appealed at 05-1717 and 05-2527; and Appellants will be prejudiced if this honorable court does not grant interlocutory appeal, prior to rule 26 disclosures. Therefore, Appellant respectfully moves this appeal court to enter an order accepting Appellant's interlocutory appeals, filed at 05-1717 and 05-2527.

Respectfully submitted,
/s/Mary Ellen Chajkowski, Esquire
Counsel for Appellants

May 31, 2005

IN THE UNITED STATES DISTRICT
IN THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s)

PLAINTIFFS' MOTION FOR JUDICIAL RECUSAL

AND NOW come the Plaintiffs, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Move the district court, in the person of the Honorable Thomas Hardiman, to Recuse himself from presiding over this civil action:

1. A Motion for Recusal is appropriate and should be granted when a Judge shows

bias toward one party such that judicial rulings and remarks made during the course of litigation display deep-seated favoritism or antagonism, such as would prejudice that party. Liteky v. United States, 510 U.S. 555, 556 (1994). In this case, the judicial bias here has prejudiced the Plaintiffs.

2. March 1, 2005, the District Court ordered the parties' counsel to appear for oral argument March 10, 2005, where the Defendant's denial that it was an employee benefits plan insurer was restated. (Exhibit **A**).

3. The district court personalized its remarks regarding Plaintiff's counsel, using '*your case*' and '*your client*' while the district court used '*Defendants*,' the proper procedural term, in reference to Defendants (Exhibit **B**, at p.3, L.21).

4. The district court stated that it held oral argument so as to "*explain in as genteel a way as possible*" that Plaintiffs' counsel had entered "*unorthodox*" and "*inappropriate pleadings*." (Exhibit **B**).

5. The district court erred, as quoted in paragraph 4 above, as the district court was referring to Petitions and Motions entered by Plaintiffs' counsel, which were not "*pleadings*," according to Fed. R. Civ. P. 7(a).

6. The district court has not enforced Fed. R. Civ. P. 26, requiring informational disclosures, to date; instead, the district court entered a Court Rules Order on January 14, 2005. (Record).

7. Non-enforcement of Rule 26 has prevented Plaintiffs from ascertaining whether additional defendants should be joined.

8. Despite *dismissing, with prejudice*, Plaintiffs' state law bad faith claim under *Barber v. Unum Life Ins. Co. of America*, 383 F.3d 134 (3d Cir. 2004)(ERISA preemption of Pennsylvania state insurance bad faith law), the district court has insisted that Plaintiffs' appeal is interlocutory and punished Plaintiff accordingly, by refusing to grant Plaintiff's Petition for an Extension of time to Amend (Exhibit **B**).

9. The district court stated March 10, 2005, that dismissal of Plaintiffs' bad faith claim with prejudice functions as a final adjudication on the merits. (Exhibit **A**).

10. The district court's refusal to grant Plaintiffs' Petition for an Extension of Time to Amend has prejudiced Plaintiffs by not allowing them to join their securities and antitrust claims arising out of the same transaction as the

ERISA claim, which may wrongfully give rise to later defenses of preclusion and/or *res judicata*.

11. The district court *sua sponte* qualified Defendant Highmark as an ERISA insurer at a hearing March 10, 2005, contrary to Defendant's written pleading, a violation of Plaintiffs' due process on a material issue. (Exhibit **A,** 92b, p. 8, lines 11-17).

12. The district court admonished Plaintiffs' counsel with the prospect of
Rule 11 sanctions for appealing the district court's dismissal, with prejudice, of Plaintiffs' state bad faith claim (Exhibit **A** at 92b, p. 9, line 22).

13. The district court's Rule 11 admonishment, if intended to chill the advocacy of Plaintiffs' counsel constitutes judicial prejudice to Plaintiffs' claim for punitive damages as failure to appeal the district court's dismissal, with prejudice, may render that dismissal a final decision on the merits.

14. In its February 1, 2005, Memorandum Opinion, the district court prejudiced Plaintiffs when it applied *Mitchell v. Cellone,* No. 01-2028, 2003 U.S. Dist. LEXIS 22347, at *6 (W.D.Pa. November 71, 2003), and stated the district court would not accept *unwarranted inferences*, inconsistent with the court's statement acknowledging Plaintiffs' *undisputed allegation* that Defendant profited by denying coverage and later submitting a claim for full state reimbursement on Plaintiff's surgery (Exhibit **C**).

15. Application of *Mitchell,* to this set of facts, demonstrates district court bias against Plaintiffs' counsel and prejudicial effect toward Plaintiffs' claim (Id.).

16. The district court, by entering decisions as to evidence at the pleading stage, where discovery has not yet taken place, functions to unduly limit Plaintiff's scope of discovery (Exhibit C) and admission of relevant, probative evidence.

WHEREAS, for cause shown by the foregoing reasons, Plaintiff reasonably believes that the district court, in the person of the Honorable Thomas Hardiman, demonstrated, through judicial remarks and rulings, a bias sufficiently serious, as to result in prejudice to Plaintiff. Therefore, in the interest of fair and impartial application of the laws, Plaintiff moves the Honorable Thomas Hardiman, in his capacity as presiding judge, to Recuse himself from this civil action.

WHEREFORE, the Plaintiffs, unduly prejudiced by prolonged litigation, further request an expedited hearing and that the relief requested be granted on an expedited basis.

Respectfully submitted,

_____

Mary Ellen Chajkowski, Esquire

June 8, 2005

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

PLAINTIFFS' REPLY TO DEFENDANT'S RESPONSE TO MOTION FOR RECUSAL

AND NOW come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Reply to Defendant, Highmark's Response to Plaintiffs' Motion for Judicial Recusal.

1. Plaintiffs ask the district court to fully consider the fact that Defendant chose not to respond to every item in Plaintiffs' Motion, which must be construed in favor of Plaintiffs.

2. Defendant's Counsel asserted it had not received a copy of Plaintiffs' Motion but has nevertheless responded to it. Moreover, Plaintiffs mailed Defendant a copy of the motion June 8, 2005, as stated in the certificate of service.

3. In Plaintiffs' Motion, Plaintiffs seek recusal of Judge Thomas Hardiman, the federal court judge before whom this case has proceeded.

4. In Plaintiffs' Motion for Judicial Recusal, Plaintiffs have set forth a factual and legal basis for the recusal of Judge Hardiman.

5. Defendant cites 28 U.S.C. §§ 144 and 455 as the relevant statutory provisions regarding judicial recusal.

6. The language of 28 U.S.C. § 144 is unclear as to whether it refers to a judicial officer recusing himself or being disqualified.[2] If 28 U.S.C. §144 does apply to a judicial officer's self-recusal, Plaintiffs' Motion for Judicial Recusal acts as the affidavit required under this section. Plaintiff reasonably makes this request in good faith based upon the record.

7. Where Defendant cites authority requiring that "a reasonable person would conclude that a personal as distinguished from a judicial bias exists." Defendant's Response ¶ 7, *citing United States v. Enigwe*, 155 F.Supp.2d 365, 369 (E.D.Pa. 2001). Plaintiff argues that the bias stems from an extrajudicial source: the Judicial Officer's apparent animosity and personal dislike toward Plaintiffs' Counsel. However, because this section is unclear as to whether it applies to the instant case, it should not apply. Thus, the precedent cited by Defendant would be inapposite.

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[2] Whenever a party to any proceeding in a district court makes and files a timely and sufficient affidavit that the judge before whom the matter is pending has a personal bias or prejudice either against him or in favor of any adverse party, such judge shall proceed no further therein, but another judge shall be assigned to hear such proceeding.

The affidavit shall state the facts and the reasons for the belief that bias or prejudice exists, and shall be filed not less than ten days before the beginning of the term at which the proceeding is to be heard, or good cause shall be shown for failure to file it within such time. A party may file only one such affidavit in any case. It shall be accompanied by a certificate of counsel of record stating that it is made in good faith.

8. Recusal is appropriate pursuant to 28 U.S.C. 455(a)[3], which provides that a judicial officer should

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[3] (a) Any justice, judge, or magistrate judge of the United States shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned.

(b) He shall also disqualify himself in the following circumstances:

(1) Where he has a personal bias or prejudice concerning a party, or personal knowledge of disputed evidentiary facts concerning the proceeding;

(2) Where in private practice he served as lawyer in the matter in controversy, or a lawyer with whom he previously practiced law served during such association as a lawyer concerning the matter, or the judge or such lawyer has been a material witness concerning it;

(3) Where he has served in governmental employment and in such capacity participated as counsel, adviser or material witness concerning the proceeding or expressed an opinion concerning the merits of the particular case in controversy;

(4) He knows that he, individually or as a fiduciary, or his spouse or minor child residing in his household, has a financial interest in the subject matter in controversy or in a party to the proceeding, or any other interest that could be substantially affected by the outcome of the proceeding;

(5) He or his spouse, or a person within the third degree of relationship to either of them, or the spouse of such a person:

(i) Is a party to the proceeding, or an officer, director, or trustee of a party;

(ii) Is acting as a lawyer in the proceeding;

(iii) Is known by the judge to have an interest that could be substantially affected by the outcome of the proceeding;

disqualify himself where his impartiality might reasonably be questioned. This part is disjunctive with 455(b), which involves personal bias or prejudice concerning a party. Only one need be true rather than both. Moreover, whether a judicial officer's impartiality might be questioned is an objective test: it is not whether the judge believes this to be true, but whether the reasonable person would believe it to be true. *Clemmons v. Wolfe*, Docket No. 02-4457 at 3 (3d Cir. 2004)(**marked as precedential**).

9. Plaintiffs' allegations offer evidence as to extrajudicial bias and thus are sufficient as a matter of law. For example, comments referred to in Plaintiffs' Motion for Judicial Recusal reflect a personal animosity and bias toward Plaintiffs' Counsel. The comment referred to in Motion Paragraph 4, which describes Plaintiffs' course of action as "unorthodox," and where the Judge goes on to describe this course of action as frivolous. However, Defendant has filed no motions regarding these allegedly frivolous pleadings; moreover, there is no record of Defendant's discontent. Finally, Judge Hardiman may know of reasons for extrajudicial bias, as his words and actions demonstrate, of which Plaintiffs are not specifically aware.

10. Even if the examples cited in Plaintiffs' Motion demonstrating uneven use of "you" and "your" are incorrect or insufficient, Plaintiffs' Motion contains various other examples which demonstrate bias toward Plaintiffs.

11. Fed.R.Civ.P. 26 requires an initial disclosure. Although the Court entered its Rules Order January 14, 2005 and Plaintiffs did not appeal the dismissal of the state law bad faith claim until March 3, 2005, and Defendant submitted its

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(iv) Is to the judge's knowledge likely to be a material witness in the proceeding.

Answer and Affirmative Defenses February 16, 2005, no disclosure had occurred.

12. Although the Court's bias is shown through rulings and actions made in the course of litigation, they demonstrate a deeper bias toward Plaintiffs' Counsel. Thus, a reasonable person knowing all the circumstances may harbor doubts concerning Judge Hardiman's impartiality toward this action.

13. Where Plaintiffs have set forth evidence such that a reasonable person may harbor doubts as to the Court's impartiality, Plaintiffs' Motion for Judicial Recusal should be granted.

WHEREFORE, Plaintiffs, Donna Scheibler and William Scheibler, reasonably believe that sufficient factual and legal basis exists for the Honorable Thomas Hardiman to recuse himself, Plaintiffs submit this Reply to Defendant's Response to Plaintiffs' Motion for Judicial Recusal.

Respectfully submitted,

Mary Ellen Chajkowski
June 28, 2005 Attorney for the Plaintiffs

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT - No. 05-1717

Scheibler vs. Highmark Blue Sheild

QUESTIONS PRESENTED FOR "*EN BANC*" APPELLATE REVIEW

I.

Whether Appellants' substantive right to due process warrants this appellate court's exercise of jurisdiction to hear an interlocutory appeal, under 28 U.S.C. section 1292(b), as a recent decision by a panel of the Third Circuit binds the district court to preempt a neutral state law intended to regulate and sanction an insurer's "bad faith" failure to process insurance claims? Barber v. Unum Life , 383 F.3d 134 (3d Cir. 2004).

II.

Whether ERISA preemption of state claims for "bad faith" medical insurance violations will alter the practice of medicine for "plan" participants in the Third Circuit?

III.

Whether the Third Circuit application of preemption to an employee insured's "pooled" allocation of risk for medical insurance coverage warrants *en banc* review to distinguish it from an employer insured's "contractual" allocation of risk accepted in purchasing a group disability insurance policy; at a minimum requiring that an insurer respond to Complaint allegations that it failed to provide a written appeal procedure and failed to process its insured's medical coverage claim in "good faith" pursuant to 42 Pa. C.S. Section. 8371, prior to litigating an insured's ERISA civil enforcement claim?

PROCEDURAL SUMMARY

Appellant filed a Petition for Reconsideration of the February 1, 2005 order, which granted Appellee's Motion to Dismiss based on ERISA preemption and dismissed with prejudice Appellant's state law claim against Appellee for "bad faith" insurance violation. Appellant's Petition cited:

1) the absence of a qualified "approved plan" to enforce under ERISA[4]

2) Appellee's failure to specify "plan" language excluding Appellant's coverage;

3) Appellee's failure to cite any written appeal procedure available to Appellant;

4) Appellee's May 17, 2004 letter, which contradicts its ERISA liability denial.

The district court ordered Appellee to respond to the Petition for Reconsideration. Appellee filed non-responsive pleadings denying ERISA liability based on a contract with Appellant's employer. However, Appellee did not attach that contract to its pleading. Procedurally, Appellee's contradictory Motion to Dismiss based on preemption and its pleadings denying ERISA liability based upon contract are impermissible. Procedurally, Appellee eviscerated Appellant's due process and punitive damages claim.

The district court failed to give precedence to Appellant's right to due process and it failed to construe all facts alleged in Appellant's favor, facts which permit Appellant recovery for "bad faith" punitive damages against Appellee, where an ERISA "plan" relationship between the parties is void and ERISA civil enforcement is not applicable.

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[4] (see Appellant's Complaint Exhibit A)

FACTUAL SUMMARY

Appellant William Scheibler was diagnosed with cancer shortly after returning from active duty in the Gulf War. Appellee provided medical coverage for Appellant's tonscillar carcinoma, his 1997 radical neck dissection, depression and cancer treatment, including extensive radiation that finally necessitated oral surgery in 2004. Therefore, Appellee knowingly and callously disregarded Appellants' treating physician letters, which detailed the medical necessity of Appellant's surgery.

Appellant Donna Scheibler selected Appellee from medical insurers offered by her employer, as Appellee insured William Scheibler prior to disability from his own employment. Appellant participates with employer in payment for her family's coverage.

Appellant's Petition for Reconsideration alleged that Appellee's May 17, 2004 written statement that Appellee did an appropriate medical review were not supported by documentary evidence (See Complaint Exhibit **A**), to which Appellee failed to respond with specificity understood by the participants. Appellee breached its regulatory duty to offer Appellants a written appeal procedure, therefore there was no ERISA due process in place for Appellants to contest Appellee's unwarranted denial of medical coverage.

Appellee approved payment of Appellant's preoperative hyper baric treatments but denied coverage for Appellant's surgery, an unnecessary delay that compromised Appellant's limited ability to heal from the oral surgery. Appellee's delayed denial of medical coverage occasioned unnecessary pain, suffering and economic losses.

Appellee knew or should have known, through its own records, that Appellant William Scheibler suffered more

than ten years from disabling illness, disfigurement, depression and economic hardship. Appellee denied coverage and Appellants paid for the oral surgery, which created economic chaos in their family.

In response to Appellant's Complaint, Appellee filed pleadings that procedurally eviscerated Appellant's "bad faith" state insurance claim, first filing a Motion to Dismiss the state claim based on preemption, which the district court granted. Appellee then filed pleadings denying ERISA liability based upon an unspecified contract with the employer.

DISCUSSION

I.. Material disputed facts were not litigated in the case *sub judice*. Therefore, Appellant's substantive right to due process may not be barred by preemption.

Appellants' substantive right to due process and equal protection of the law must be given full force and effect to support a valid district court decision. All state legislation must pass state constitutional muster to be enacted. The Pennsylvania constitution can afford more due process protection to its citizens than the United States Constitution, which the district courts must strictly construe in favor of the insureds, as the ERISA protected class of persons, when preemption adversely effects their rights.

Congress expressly created a Savings Clause to make an exception to preemption for state laws that regulate insurance, securities and banking. 42 Pa. C.S. sec. 8371 is an insurance law that neutrally regulates insurance, which is distinctly different from the Texas statute at issue in Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004). The Supreme Court applied preemption where HMO insureds challenged plan prescription benefits by trying to incorporate an HMO's

duty to 'exercise ordinary care' under state law. The Davila insured was denied coverage for a name brand prescription drug and filed suit for injury sustained by taking alternate medication. The insurer provided notice that the Davila insured's physician had not sought pre-certification, but that the plan would cover Vioxx if the Davila insured's physician indicated that the less costly drug was contraindicated. The insurer's letter provided a list of alternative medications available under the plan's formulary without pre-certification, as well as the grievance and independent review procedures available to the Davila insured. Id. In contrast, Appellee provided no alternatives and no appeal procedure to Appellants.

The Pennsylvania Supreme Court extended Pennsylvania's common law to include claims for bad faith in the context of insurer's failure to use good faith in settling cases filed against the insured. Birth Center v. St. Paul Companies, Inc., 567 Pa. 386 (2001), which may extend to an insurer's failure to process a claim in good faith. Appellee had an independent duty, defined by ERISA regulations, to provide written notice of its medical coverage denial; in terms of sufficient specificity to be understood by the participant; and to set forth its appeal and review process to Appellants. Therefore, Appellee breached its ERISA regulated duty and its duty under state insurance law.

II. Appellants present a compelling reason for *en banc* review, as "plan" participants will be treated inequitably in the Third Circuit if preemption bars "bad faith" claims of 'plan' insureds only.

Third circuit "plan" insureds are entitled to equitable application of state laws regulating insurance claims. If "plan" insureds are inequitably and routinely preempted from pursuing their right to litigate claims for an insurer's bad

faith denial of medical coverage, a disturbing pattern will emerge in medical care for "plan" insureds. For example, medical decisions for "plan" insureds may become compromised by "plan" exclusion language drafted by insurers.

The question of medical necessity is determined objectively as being in accordance with general medical practice. That may become compromised for "plan" insureds whose insurers become insulated from sanctions for "bad faith" by preemption.

Appellants' right to litigate common law claims for punitive damages for Appellee's 'reckless disregard for the rights of the Appellants' and Appellee's undisputed 'unjust enrichment' at the expense of Appellants are not abrogated by their "plan" status.
Recovery under a reasonable extension of statutory relief would create more certainty.

III. There are substantive reasons for the Third Circuit Court of Appeals to grant *en banc* review to its application of the U.S. Supreme Court's two prong preemption test to Appellant employee's "bad faith" medical insurance claim.

Disputed material facts distinguish Appellants claim from Barber, where an employee's "bad faith" claim against insurer for coverage denied under a group disability policy purchased by employer was held preempted by ERISA.

1) The "pooled" risk in medical insurance coverage and Appellants' shared payment with employer for coverage, qualify for the preemption exception.

2) The allocation of risk was defined by "contract" in a group disability policy purchased by the employer in Barber and the preemption exception did not apply.

3) Losses for medical payments made by Appellee are state subsidized, while Appellant's economic losses are not state subsidized.

4) Appellant was denied coverage for medically necessary oral surgery by Appellee whose 2004 reserves were over two billion dollars and whose wholly owned dental insurance subsidiary, United Concordia, brought in over one billion dollars in revenue in 2004, as the fifth largest dental insurer in the United States.

5) State subsidy to health insurers is intended to cover the state's uninsured and underinsured and to neutrally protect the economic interest of all insureds who pay for medical coverage, without exception for 'plan' coverage.

6) Pursuant to the ERISA savings clause and 42 Pa. C.S. section 8371, the 1990 state legislature intended to regulate Appellee, an insurer that it subsidizes, and to sanction and deter Appellee's "bad faith" failure to process claims for all insureds.

7) The ERISA savings clause creates an express exception for state regulation of insurance, securities and banking. Therefore, 42 Pa. C.S. section 8371 punitive damages may be considered as an upward deviation of compensatory damages.

8) The Appellants' allocation of risk was substantially effected by Appellee, which meets the requirements for the Miller exception to preemption.

CONCLUSION

Appellants qualify for both prongs of the Miller test 538 U.S. 329 (2003), as Appellee's denial of medical coverage substantially effected and disrupted the risk pool. Second, there is no approved "plan" to enforce under ERISA. Third, Appellants have endured duress and will be unnecessarily prejudiced by prolonged appellate litigation. Fourth, the state has a substantial interest in enforcing 42 Pa. C.S. section 8371 against bad faith actions of insurers who deny medical coverage that the state subsidizes. Fifth, Appellants allegation that Appellee was unjustly enriched by denying coverage and submitting Appellant's bill for reimbursement was not disputed by Appellee.

WHEREAS, the district court failed to take all facts alleged and any responses thereto, including Appellee's failure to respond, in favor of Appellant. The facts, if proven, support Appellants' claims which will entitle them to relief precluding dismissal.

WHEREFORE, Appellant respectfully petitions the Third Circuit Court of Appeals to do an *en banc* review of preempting 42 Pa. C.S. section 8371, the state bad faith insurance law, as it applies to medical insurance coverage.

Respectfully Submitted,

Mary Ellen Chajkowski, Esquire
Counsel for Appellants

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 05-1717 & 05-2527

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband, :
Appellant(s).

v.

HIGHMARK BLUE SHIELD,
Respondent(s).

APPELLANTS'
PETITION FOR REHEARING *EN BANC*

AND NOW, come the Appellants, by and through their attorney, Mary Ellen Chajkowski, Esquire to Petition this Honorable Court to Review *en banc* this Court's July 26, 2005 Order dismissing Appellants' appeal for lack of finality and, thus, subject matter jurisdiction.

1. Appellants express a belief, based on a reasoned and studied professional judgment by their Counsel, that the panel's Decision dismissing Appellant's appeals for lack of appellate jurisdiction, implicates a question of exceptional importance, including the Plaintiffs' constitutional due process rights, of which review at a later point would raise insurmountable obstacles to proper remedy, as an excluded claim cannot be reinstated upon appellate review at the end of the litigation.

2. Appellants, as "plan insured" members of the protected class of persons, within the express language of ERISA and Pennsylvania's bad faith insurance regulatory statute at 42

Pa. C.S. Section 8371, filed a Complaint which alleged that Appellee Insurer's denial of coverage constituted a violation of the federal and state statutes and Appellant's substantive right to due process, which requires *strict scrutiny* appellate review.

3. Appellant seeks *en banc* appellate review of its panel decision preempting Pennsylvania's bad faith law at 42 Pa. C.S. Sec. 8371, in Barber v. Unum Life , 383 F.3d 134 (3d Cir. 2004), which may have erred in extending preemption of a dissimilar state law in Kentucky Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003) to Pennsylvania's bad faith insurance law.

4. Barber v. Unum Life , 383 F.3d 134 (3d Cir. 2004) an interlocutory appeal taken under 28 U.S.C. section 1292(b), decided by a panel of this Court, inequitably and adversely preempts "plan insureds" only from civil enforcement of Pennsylvania's neutral bad faith insurance statute, a violation of federal constitutional Equal Protection.

5. Appellants' substantive right to due process warrants this appellate court's exercise of jurisdiction to hear *en banc* an interlocutory appeal, under 28 U.S.C. section 1292(b), as a recent decision by a panel of the Third Circuit binds the district court to preempt a neutral state law intended to regulate and sanction an insurer's "bad faith" failure to process insurance claims. Barber v. Unum Life , 383 F.3d 134 (3d Cir. 2004).

6. Appellant's federal protection here includes the Department of Labor Regulations, requiring notice, specificity in denial, and a written appeal procedure, in order to qualify Appellee to first establish "ERISA standing" before filing its motion to dismiss Appellant's "bad faith" insurance claim which did not happen here.

7. The Sixth Circuit in Adkins cited World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286 (U.S. 1980), where it held that "a judgment rendered in violation of due process is void in the rendering State and is not entitled to full faith and credit elsewhere." Woodson at 291, quoted in Adkins, 2005 WL 486670 at 5.

8. Appellant's right to due process takes precedence over procedural requirements that an Order be certified, within the meaning of 28 U.S,C. 1291; and warrants an interlocutory appeal, under 28 U.S.C. 1292(b).

9. Appellant must not be sanctioned where the district court failed to certify its order, where statements made by the court to the parties assert its intent to be final, as Appellant's claims were **dismissed with prejudice**.

10. Appellant's appeal under 05-1717 petitions the district court to note the ambiguity regarding Appellee's standing, and therefore the court's jurisdiction, where Appellee:

A) Files a motion for dismissal based on ERISA preemption;
B) Then denies being an ERISA insurer in its Answer filed after dismissal;
C) Admits making certain payments on behalf of its insured but denies that it made the decisions in refusing certain other payments, including surgery.
D) Where Appellee failed to deny that it profited by seeking full reimbursement.

11. The ambiguity surrounding Appellee's standing and the court's subject matter jurisdiction were created by the district court's failure to enforce Rule 26 from the outset.

12. Appellants' substantive right to due process and equal protection of the law must be given full force and effect to support a valid district court decision. All state legislation must pass state constitutional muster to be enacted.

13. The Pennsylvania constitution can afford more due process protection to its citizens than the United States Constitution, which the district courts must strictly construe in favor of the insureds, as the ERISA protected class of persons, when preemption adversely effects their rights.

14. Congress expressly created a Savings Clause to make an exception to preemption for state laws that regulate insurance, securities and banking. 42 Pa. C.S. sec. 8371 is an insurance law that neutrally regulates insurance, which is distinctly different from the Texas statute at issue in Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004). The Supreme Court applied preemption where HMO insureds challenged plan prescription benefits by trying to incorporate an HMO's duty to 'exercise ordinary care' under state law. The Davila insured was denied coverage for a name brand prescription drug and filed suit for injury sustained by taking alternate medication. The insurer provided notice that the Davila insured's physician had not sought pre-certification, but that the plan would cover Vioxx if the Davila insured's physician indicated that the less costly drug was contraindicated. The insurer's letter provided a list of alternative medications available under the plan's formulary without pre-certification, as well as the grievance and independent review procedures available to the Davila insured. Id. In contrast, Appellee provided no alternatives and no appeal procedure to Appellants.

15. The Pennsylvania Supreme Court extended Pennsylvania's common law to include claims for bad faith in the context of insurer's failure to use good faith in settling cases filed against the insured. Birth Center v. St. Paul

Companies, Inc., 567 Pa. 386 (2001), which may extend to an insurer's failure to process a claim in good faith. Appellee had an independent duty, defined by ERISA regulations, to provide written notice of its medical coverage denial; in terms of sufficient specificity to be understood by the participant; and to set forth its appeal and review process to Appellants. Therefore, Appellee breached its ERISA regulated duty and its duty under state insurance law.

16. Appellants present a compelling reason for *en banc* review, as "plan" participants will be treated inequitably in the Third Circuit if preemption bars "bad faith" claims of 'plan' insureds only.

17. Third Circuit "plan" insureds are entitled to equitable application of state laws regulating insurance claims. If "plan" insureds are inequitably and routinely preempted from pursuing their right to litigate claims for an insurer's bad faith denial of medical coverage, a disturbing pattern will emerge in medical care for "plan" insureds. For example, medical decisions for "plan" insureds may become compromised by "plan" exclusion language drafted by insurers.

18. The question of medical necessity is determined objectively as being in accordance with general medical practice. That may become compromised for "plan" insureds whose insurers become insulated from sanctions for "bad faith" by preemption.

19. Appellants' right to litigate common law claims for punitive damages for Appellee's 'reckless disregard for the rights of the Appellants' and Appellee's undisputed 'unjust enrichment' at the expense of Appellants are not abrogated by their "plan" status.
Recovery under a reasonable extension of statutory relief would create more certainty.

20. There are substantive reasons for the Third Circuit Court of Appeals to grant *en banc* review to its application of the U.S. Supreme Court's two prong preemption test to Appellant employee's "bad faith" medical insurance claim.

21. Disputed material facts distinguish Appellants claim from Barber, where an employee's "bad faith" claim against insurer for coverage denied under a group disability policy purchased by employer was held preempted by ERISA.

1) The "pooled" risk in medical insurance coverage and Appellants' shared payment with employer for coverage, qualify for the preemption exception.

2) The allocation of risk was defined by "contract" in a group disability policy purchased by the employer in Barber and the preemption exception did not apply.

3) Losses for medical payments made by Appellee are state subsidized, while Appellant's economic losses are not state subsidized.

4) Appellant was denied coverage for medically necessary oral surgery by Appellee whose 2004 reserves were over two billion dollars and whose wholly owned dental insurance subsidiary, United Concordia, brought in over one billion dollars in revenue in 2004, as the fifth largest dental insurer in the United States.

5) State subsidy to health insurers is intended to cover the state's uninsured and underinsured and to neutrally protect the economic interest of all insureds who pay for medical coverage, without exception for 'plan' coverage.

6) Pursuant to the ERISA savings clause and 42 Pa. C.S. section 8371, the 1990 state legislature intended to regulate Appellee, an insurer that it subsidizes, and to sanction and deter Appellee's "bad faith" failure to process claims for all insureds.

7) The ERISA savings clause creates an express exception for state regulation of insurance, securities and banking. Therefore, 42 Pa. C.S. section 8371 punitive damages may be considered as an upward deviation of compensatory damages.

8) The Appellants' allocation of risk was substantially effected by Appellee, which meets the requirements for the Miller exception to preemption.

22. If Appellants' due process and equal protection rights are not protected by granting jurisdiction for this appeal at this stage of the litigation, they will lose important rights for which later appeal will afford no adequate remedy.

23. The District Court Order has not been entered, nor would the District Court Judge grant an allowance for interlocutory appeal, because the District Court Judge harbors animosity toward Appellant's Counsel, a Writ of Mandamus to issue a *Recusal* ruling is presently before this court.

WHEREFORE, Appellant respectfully petitions the Third Circuit Court of Appeals to rehear *en banc* Appellant's appeal of the District Court dismissal of Appellants' punitive damages claim by preempting 42 Pa. C.S. section 8371, the state bad faith insurance law, as it applies to medical insurance coverage.

Appellant's Amended and Corrected Petition for *en banc* Rehearing

24. Paragraphs one (1) through (23) twenty-three are hereby incorporated.

25. Appellants' counsel hereby amends and corrects Appellants' Petition for a Rehearing *en banc* and submits the following:
    a) a Rule 35.1 required statement;
    b) a copy of the Order appealed;
    c) a copy of Appellee's request for additional defendant without court order;
    d) a copy of the court's compliance letter;
    e) a copy of the 05-2527 docket showing Appellee out of compliance 6/6/05.

26. Appellant reasonably believes that appellate jurisdiction lies, as the 05-1717 appeal is from a final order and that the 05-2527 appeal is from a collateral order.

27. Appellee did not file a petition to have the order certified as final; the district court stated that "with prejudice" meant finality; and Appellant, prejudiced by the court's failure to certify the order, appeals based on substantive finality.

28. The district court stated that it granted Appellant thirty days to Amend and denied Appellant an extension of time to Amend in opposition to the appeal at 05-1717, making the order at 05-2527 a collateral order to 05-1717.

29. Appellant's Petition for a Writ of Mandamus requesting action on Appellant's Motion for Recusal, is pending action before this court.

30. The court's Compliance letter to Appellant inequitably failed to list the least restrictive "strike the document" option available under the sanctions rule.

31. Appellees inequitably received no Compliance letter from the Clerk for failing to comply with the court's June 6, 2005 directive.

32. Appellants Petition for *en banc* Rehearing was mailed 08/09/05, within 14 days.

33. Appellee did not argue prejudice and filed no request for sanctions on Appellant.

34. Imposition of sanctions on Appellant and or dismissal of this action would prolong litigation, an unnecessary duress on Appellants and may be constitute bad faith; pretext for bias; or inequitable application of the rules, a violation of the fourteenth amendment. "Procedural due process rules are meant to protect persons not from deprivation, but from mistaken or unjustified deprivation of life, liberty or property." U.S.C.A. Const. Amend. 14. Carey v. Piphus, 435 U.S. 247 (1978).

35. August 11, 2005, Appellee's counsel filed a request to include an additional defendant, without requesting a hearing or a court order.

36. Appellant reasonably believes the panel erred in relying on Quakenbush v. Allstate, 517 U. S. 707, 712 (1996), as the holding in Quackenbush is limited to actions seeking common-law damages that are in federal court by way of diversity jurisdiction. Coles, et al v. Street, 38 Fed. Appx. 829 (3rd Cir. 2002).

WHEREAS, Appellant has provided substantive reasons to grant its Petition for Rehearing *en* banc of the July 26, 2005 Order; and Appellant has shown cause to file Appellant's Amended/Corrected document; and Appellant hereby moves this honorable court for leave to file Appellant's Amended/Corrected Petition for Rehearing and to grant Appellant's Petition for a Rehearing *en banc* to review medical coverage issues of great importance to insured individuals, medical care providers and healthcare administrators in the Third Circuit.

Respectfully Submitted,

Mary Ellen Chajkowski, Esquire

IN THE COURT OF COMMON PLEAS OF WESTMORELAND COUNTY, PENNSYLVANIA
Civil Division No. cv 05- 7642

DONNA SCHEIBER,
Plaintiff,

vs.

HIGHMARK BLUE SHIELD; and jointly, separately, or severally,
KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue,
Defendant(s).

COMPLAINT IN CIVIL ACTION

AND NOW, comes the Plaintiff, Donna Scheibler, by and through her attorney, Mary Ellen Chajkowski, Esquire, and files the following COMPLAINT IN CIVIL ACTION against Highmark Blue Shield; and jointly, separately or severally, Keystone Health Plan West, d/b/a Security Blue, to claim damages from Defendant(s) in addition to the medical coverage she purchased for her family, by making co-payments through her employment, and represents the following in support thereof:

Jurisdiction - 42 Pa. C.S.A. s 8371

This action is brought under, and jurisdiction is vested in this Court through 42 Pa. C.S.A. s 8371, Pennsylvania Bad Faith Statute, which regulates the insurance industry, mandating accountability on the part of all insurance companies for any frivolous or unfounded refusal to provide coverage in accordance with an applicable policy of insurance.

Parties

1. Plaintiff DONNA SCHEIBLER is an adult individual who resides in Westmoreland County, mailing address: RD #2, Box 468, Greensburg, PA 15601.

2. Defendant(s) HIGHMARK BLUE SHIELD; and *jointly, separately, or severally*, KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue, which do business in Pennsylvania and are headquartered at Fifth Avenue Place, Pittsburgh, PA 15222.

Privity

3. Plaintiff Donna Scheibler, as an employee of ABB, Inc., is enrolled as a beneficiary of the company's health care benefits *plan*. Plaintiff's family is entitled to the benefits of the health care *plan*.

4. Plaintiff Donna Scheibler selected Highmark Blue Shield, from several providers offered to ABB employees, makes co-payment with her employer.

5. Plaintiff Donna Scheibler selected Highmark Blue Shield for her family, as William Scheibler, her husband, needed to maintain continuous coverage with the same insurer he had prior to disability in 1995 (*deceased in 2005*).

6. At all times relevant hereto, the Defendant(s), Highmark Blue Shield and/or Keystone Health Plan West, d/b/a Security Blue, provided health care insurance pursuant to employee benefit *plans* on behalf of ABB employee/Plaintiff Donna Scheibler.

7. Defendant(s), Highmark Blue Shield and/or Keystone Health Plan West, d/b/a Security Blue, are employee benefits *plan* insurer(s) in the State of Pennsylvania.

8. Highmark Blue Shield offers an address for its Member Grievance & Appeals Department at P.O. Box 535095, Pittsburgh, PA 15253-5095 (Exhibit **A**).

Re: Plaintiff v. Highmark at 04-cv-1928
Count I ERISA/Count II Bad Faith

9. Defendant(s) failed to avail themselves of federal jurisdiction to litigate either claim; Defendant(s) created ambiguity about 'standing' by unilaterally naming a second defendant after its motion to dismiss as preempted; and, a later Answer in contradiction.

10. Plaintiff named two Defendant entities based un-litigated actions, averments and admissions or waiver made in federal court by Defendants 04-cv-1928 WD

Control Group

11. In 2004, Defendant Highmark reported to the public:
a) Profits in excess of three hundred nine million dollars;
b) 'Blues' reserves of four billion dollars, two billion dollars held by Highmark 2004;
c) Highmark's top executive paid 1.7 million dollars;
d) Fewer than ten Highmark's top executives paid eight (8) million dollars total 2004;
e) A wholly owned dental insurance subsidiary earned one billion dollars in revenue 2004.

13. By operation of law, Defendant(s), its fiduciaries, affiliates and assignees have:
a) Constructive Notice to conform to Department of Labor (DOL) regulations;
b) A duty to provide due process understood by *plan* claimants; and
c) Actual Notice of non-compliance, pursuant to Plaintiff's federal lawsuit.

Therefore, its failure to investigate, resolve, settle or fully litigate constituted bad faith.

14. Defendant(s) acted as a control group on behalf of both named defendants:
a) Highmark's May 2004 letter to Plaintiff authorized ERISA appeals;

b) Highmark moved to dismiss the 42 Pa. S8371 bad faith claim, as preempted;

c) Highmark's Answer then denied that it is an ERISA insurer;

d) Highmark's Answer referred to a contract with ABB and did not attach it;

e) Highmark attempted to add a second defendant by correspondence;

f) Highmark failed to avail itself of federal jurisdiction to litigate either claim.

15. Defendant(s) control group(s) is/are composed of a small number of highly compensated executives, subject to the authority of one or more board(s) of directors.

16. Defendant(s) fund the *plan*, assign risk, set rates and approve or deny claims.

17. Plaintiff reasonably believes that information on Defendant(s) constitution(s), by-laws, articles of incorporation, Boards and self-governance are material to this claim.

Compliance

18. Approved *plan* documents and written appeal procedures are compliance requirements; without which, coverage is whatever Defendant(s) arbitrarily decide.

19. Defendants' failure to approve ABB's August 2003 '*Plan* draft' and its failure to offer a written appeal procedure render exclusionary language unenforceable.

20. Plaintiff hereby reserves the right to Amend this Complaint to conform to evidence within the exclusive control of Defendant(s), as multiple statutory violations

regulating benefit *plans* were revealed in Plaintiff's 2004 un-litigated federal action.

Savings Clause

21 Plaintiff's bad faith claim is a Pennsylvania action, as the Savings Clause' insurance, securities and banking exceptions to federal preemption apply here.

22. Plaintiff reposed her trust in Defendant(s) by co-paying for medical coverage. Here, bad faith denial constitutes a 'securities' exception to preemption, where coverage denied as 'dental' v. medical, constitutes self-dealing by state subsidized entities whose wholly owned dental insurance subsidiary generated one billion dollars in 2004 revenue.

Bundling

23. Defendant Highmark's Answer admitted making certain 2004 payments on Plaintiff's claim but denied making the decision to deny the surgery claim, without revealing the identity of, or relationship to, the entity that did make the decision.

24. Defendant(s) exercise(s) coercive influence over the medical insurance market, where provisions bundled in contracts may be enforced to unilaterally drop employer groups or individuals pursuant to Defendant(s) unilateral mandatory provisions.

25. Defendant(s) failure to disclose all affiliates/subsidiaries in the federal action; and decision to edit Plaintiff's federal caption, by court correspondence, are evidence of 42 Pa. C.S.A. s8371 'bad faith' and control group *scienter* in contesting Plaintiff's claim.

Privacy

26. Plaintiff reasonably believes and therefore avers that her family's constitutional and statutory (HIPPA) right to privacy was compromised by Defendant(s).

27. The privacy violation came to light upon the death of Plaintiff's husband.

28. Plaintiff's family medical records were made available to insurers who denied coverage based on medical records available at the time coverage was approved.

29. Insurers in 2005 may have confused Plaintiff's husband's medical history with Plaintiff's deceased father in law, as the birth date, name and address were similar.

30. Plaintiff was never apprised of contracts between employer and Defendant(s), which made her family medical records accessible to Defendant(s) affiliates and others.

Intended and/or Foreseeable Consequences

31. William Scheibler, a Gulf War special forces veteran, was disabled from employment with ABB in March 1995 with health benefits covered by Defendant(s).

32. Defendant(s) covered and paid medical expenses related to Mr. Scheibler's cyst, a heart attack and stroke, *tonsillar carcinoma* and a radical neck dissection in 1997.

33. William Scheibler was not forewarned that extensive facial bone deterioration was a likely risk related to 1997 radiation treatments administered on his neck; however, Defendant(s) knew or should have known the consequence of delayed surgery.

34. In January 2004, William Scheibler's treating physicians wrote letters to Defendant Highmark, attributing William Scheibler's need for oral surgery to extensive radiation treatments that were administered for his *tonsillar carcinoma*,stating that the surgery is medically necessary.

In a letter to Defendant Insurer, Dr. Stephen Rendulich attributed William Scheibler's caries to *xerostomia:*

"Radiation induced caries should be treated as a late effect medical condition resulting from radiation therapy. Having hyperbaric oxygen prior to dental extractions would significantly decrease his risk of *osteoradionecrosis*, which, as you know, can be quite extensive in nature, resulting in the loss of jaw and significant dysfunction and deformity, requiring multiple operations to correct."

35. Defendant(s) possess expert knowledge to adequately assess medical necessity and knew, or should have known that Plaintiff's claim was medically necessary.

36. Defendant(s) knowingly made frivolous determinations on Plaintiff's claim.

37. Defendant Highmark approved payment of William Scheibler's pre-op and post-op, Hyperbaric Oxygen hospital treatments, done in preparation for surgery.

a) William Scheibler was told authorization for surgery follows.
b) Four weeks, Monday-Friday, Scheibler drove into Pittsburgh for Hyperbaric Oxygen treatments, ending in March 2004.
c) No authorization for surgery came,
d) No timely written denial came,
e) Scheiblers submitted Highmark appeal forms several times,

Misrepresentations to Congress

38. William Scheibler wrote to Pennsylvania United State Senators and his Congressman, whose offices made written inquiries to Defendant(s) on his behalf.

39. Plaintiff reasonably believes and therefore avers that Defendant(s) vague, written responses to elected federal officials constituted misrepresentations to Congress, an unconscionable act by state subsidized entities who were not in statutory compliance.

40. Defendant Highmark's May 2004 letter, asserting that Plaintiff's claim went before a review committee, was not supported by its documentation of that assertion.

41. Defendant(s) denied payment for Scheibler's surgery, scheduled March 2004, in May 2004, an egregious delay, as the untimely denial based on unspecified language.

Defendant(s)' Statutory Violations Caused Harm to Plaintiff's Family

42. Plaintiff's employment with ABB succeeded her husband's disability and provided an opportunity to maintain Defendant(s) health care coverage continuously.

43. For a period of years, prior to the events giving rise to this cause of action, William Scheibler was reasonably mobile; he enjoyed his life, his wife, school activities of their two adolescent sons, and his extended family living nearby.

44. January 2004, William Scheibler's physician requested authorization.

45. May 2004, Defendant(s) unilaterally refused to authorize payment for surgery in the dentist's office, after it approved the pre-op hospital treatments months before.

46. Defendant Highmark's state subsidy is not a dollar for dollar exchange of services for money, hospital state subsidy is based on a formulaic equation,

including past losses. Highmark was not in statutory compliance to deny Plaintiff's claim, yet displayed a flagrant disregard for Plaintiff's rights under the law in the federal litigation:

a) Highmark filed a Motion to Dismiss Plaintiff's bad faith claim based on ERISA;
b) Highmark later filed an Answer, which denied ERISA liability;
c) Highmark admitted it paid selected Scheibler medical bills;

d) Highmark denied decision-making on coverage;
e) Highmark attempted to change Plaintiff's caption by correspondence;
f) Highmark's control group failed to correct its compliance errors;
g) Highmark afforded Plaintiff's claim no due process, even in court;
h) Highmark failed to resolve or litigate both claims, bad faith and ERISA.

Count I – Specific Performance
Plaintiff v. All Defendant(s)

47. Paragraphs 1 through 46 are hereby incorporated as if more fully set forth at full length herein.

WHEREFORE, plaintiff prays:

a) that defendant(s) be ordered to specifically perform its agreement to authorize payment of all medical expenses related to this claim, under the applicable coverage co-paid by Plaintiff's through employer;

and,

b) such other general relief as may be just and proper.

Count II – Dereliction of a Duty to Deal in Good Faith
Plaintiff v. All Defendant(s)

48. Paragraphs 1 through 47 are incorporated as if set forth at full length herein.

49. Defendant(s) had a statutory duty to deal with Plaintiff in good faith, pursuant to 42 Pa. CSA s 8371 which neutrally regulates insurance, a savings clause exception; however, when state laws are preempted, courts have upheld duties by regulation to protect *plan* claimants that include DOL regulations requiring, *inter alia:*

a) timely Notice to claimant,
b) alternative treatment offered,
c) written grievance and independent review procedures;
d) physician over-ride provisions; and
e) all of the above to be understood by the participant.

See Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004).

f) Defendant(s) control group breached the above Compliance duties here.

50. Plaintiff asserts that statutory compliance duties were breached, which Defendant(s) control group willfully refused to correct in federal litigation, in bad faith.

51. Defendant(s) conduct in failing to honor medical bills constituted bad faith, in that it was a breach of a known duty, timely with the duty of good faith and fair dealing, and that it was done through a motive of self-interest or ill-will.

52. Under the above circumstances, the Plaintiffs are entitled to recover benefits due Plaintiff under the

terms of the plan, to enforce the rights under the terms of the plan, and to clarify the rights to future benefits under the term of the plan.

53. While said policy was in full force and effect, Plaintiff requested approval of benefits for her husband's oral surgery, a procedure which was recommended by his treating physician as medically necessary.

54. All conditions precedent under this policy have been performed by Plaintiff.

55. Defendant(s) failed to pay the plaintiff the sum of money due under the policy.

56. Statutory violations of medical insurers, utilizing state subsidized insurance that is funded and regulated by the legislature, must be equitably enforced by the courts; specifically, *Plan* claimant and non-*Plan* claimant rights must be adjudicated equitably. As a result of the dereliction of duty to deal in good faith on the part of the Defendant(s), Plaintiff seeks special damages for Plaintiff's economic losses and harms caused by Defendant(s), including interest, punitive damages, costs and attorneys' fees.

WHEREFORE, Plaintiff demands judgment against the Defendant(s) for the reimbursement of medical care, plus interest, cost and attorney's fees, due and owing Plaintiff for the wrongful denial of coverage for William Scheibler's 2004 surgery; and requests this honorable court enter judgment in plaintiff's favor in excess of $25,000.00

Count III – Bad Faith 42 Pa. CSA s 8371
Plaintiff v. All Defendant(s)

57. Paragraphs 1 through 56 are hereby incorporated as if more fully set forth at full length herein.

58. Defendant(s) 2004 failure to pay for William Scheibler's surgery caused him unnecessary pain and suffering, including disfigurement, and depression, which caused emotional and financial hardship on Plaintiff, his wife, their sons and Scheibler's family.

59. William Scheibler's physicians requested approval in January 2004.

60. William Scheibler became reclusive as his teeth started to fall out; he ate tapioca to ameliorate the pain and was frustrated, which altered his enjoyment of life.

61. Relying in good faith that surgery would be approved based on Defendant(s) approval of pre-op and post-op procedures, William Scheibler traveled to a Pittsburgh hospital for four weeks, Monday to Friday, for pre-op hyperbaric oxygen treatments,

62. William Scheibler's surgery was scheduled two weeks after the pre-op treatments ended, which Defendant(s) know is recommended for optimal healing.

63. The scheduled surgery was delayed for months after hyperbaric treatments, delay so remote from pre-op treatment that it caused difficulty in healing.

64. The delayed surgery caused additional delay before dentures could be fitted.

65. Plaintiff negotiated with the hospital and paid an agreed upon price for the surgery but later received statements that far exceeded the costs actually paid; in contrast, the physician fees were the same, whether covered or not covered.

66. The hospital fees were substantially varied when not covered.

67. Plaintiff realized a mortgage insurance loss in 2005 upon her husband's death.

68. Plaintiff refinanced the family home to pay for medical expenses, which cancelled William Scheibler's mortgage insurance before he died, insurance taken when he was not disabled, insurance he could not qualify for in 2004 to refinance.

69. The Pennsylvania Bad Faith Statute, 42 Pa. C.S.A. s 8371, regulates the insurance industry mandating accountability on the part of all insurance companies for any frivolous or unfounded refusal to provide coverage in accordance with an applicable policy of insurance.

70. Plaintiff avers that the Defendant(s) acted in bad faith in its actions toward her in handling the claim generally, and as set forth ins the following particulars:

    (a) In failing to consider all relevant factors and medical records to evaluate and determine the medical necessity of the surgery recommended by William Scheibler's treating physicians;

(b) In failing to properly inform Mr. Scheibler of what constitutes medical necessity and why it believed his condition did not rise to that level;

(c) In failing to appreciate the success of the surgery, as evidence of the necessity of the procedure;

(d) In failing to pay for a covered benefit given the medical evidence presented.

WHEREFORE, Plaintiff requests, pursuant to 42 Pa. C.S.A. s 8371, an award of punitive damages, court costs and counsel fees to be paid by the Defendant(s).

Count IV – Unjust Enrichment
Plaintiff v. All Defendant(s)

71. Paragraphs 1 through 70 are hereby incorporated as if more fully set forth at full length herein.

72. Plaintiff, never apprised of a contract between employer and Defendant(s), reasonably believes and hereby asserts that fee sharing and similar incentives, offered by Defendant(s)' unilateral contract terms, are bundled with denied claims for profit.

72. Defendant(s) refused to authorize payment for office surgery in addition to the pre-op and post-op hyperbaric oxygen hospital treatments it authorized, as hospital surgery is state subsidized, a publicly funded source of profit to Defendant(s).

73. Defendant(s) frivolous approval of William Scheibler's pre-surgery hospital treatments combined with its arbitrary refusal to authorize payment for surgery, under the

same applicable coverage, and its failure to timely and explicitly notify Plaintiff of the same, constitute profitable compliance/bad faith violations at Plaintiff's expense.

75. Defendant(s) wrongfully requested and accepted state subsidy for William Scheibler's surgery, as he paid for it in full by prior agreement with the hospital.

76. Defendant(s) control group willfully failed to make corrections pursuant to Actual Notice, when Plaintiff filed a federal civil action.

77. Defendant(s) failure to deny Plaintiff's federal Complaint allegation that Defendant realized a profit by claiming and accepting state subsidy for Plaintiff's surgery, must be construed against Defendant(s); enrichment at the expense of Plaintiff.

WHEREFORE, Plaintiff demands a judgment against defendant(s) in the amount defendant(s) received as a result of defendant(s) wrongful acts and the return of all property unjustly retained by defendant(s).

Count V – Violation of the Unfair Trade Practices Act

78. Paragraphs 1 through 77 are hereby incorporated as if more fully set forth at full length herein.

79. Defendant(s) actions constitute an unfair method of competition and/or unfair or deceptive act or practice, as prohibited by Pennsylvania Law.

80. Defendant(s) actions constitute a violation of the Unfair Trade Practices Act and Consumer Protection Law.

81. As a result of the Defendant(s) violation of the Unfair Trade Practices Act and Consumer Protection Law, Plaintiff has suffered harm in that she has incurred medical expenses, which should have been covered by the policy, as well as consequential damages.

WHEREFORE, the Plaintiff respectfully requests this Honorable Court enter Judgment in Plaintiff's favor and against the Defendants in an amount in excess of $25,000.00 (twenty five thousand dollars), for bad faith and consequential damages.

Respectfully submitted,
/s/Mary Ellen Chajkowski, Esquire
Counsel for Plaintiff Donna Scheibler

October 4, 2005

IN THE COURT OF COMMON PLEAS OF
WESTMORELAND COUNTY, PENNSYLVANIA
CIVIL DIVISION - No. 05- 7642

DONNA SCHEIBLER
Plaintiff,

vs.

HIGHMARK BLUE SHIELD; and jointly, separately, or severally
KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue,
Defendant(s).

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

NOTICE TO PLEAD

To: Highmark Blue Shield; and
Keystone Health Plan West,
You are hereby notified to file a written response to the enclosed Motion for Summary Judgment within thirty (30) days from service hereof or a judgment may be entered against you.

_____
/s/Mary Ellen Chajkowski, Esquire,
Counsel for Plaintiffs.

IN THE COURT OF COMMON PLEAS OF WESTMORELAND COUNTY, PENNSYLVANIA

DONNA SCHEIBER,
Plaintiff.

vs.

HIGHMARK BLUE SHIELD; and jointly, separately, or severally,
KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue,
Defendant(s).

Plaintiff's Motion for Summary Judgment

AND NOW, comes the Plaintiff, Donna Scheibler, by and through her attorney, Mary Ellen Chajkowski, Esquire, and files the following Motion for Summary Judgment against Highmark Blue Shield; and jointly, separately or severally, Keystone Health Plan West, d/b/a Security Blue, to claim damages from Defendant(s) in addition to the medical coverage she purchased for her family, and represents the following in support thereof:

Jurisdiction - 42 Pa. C.S.A. s 8371

1. This action is brought under, and jurisdiction is vested in this Court through 42 Pa. C.S.A. s 8371, the Pennsylvania Bad Faith Statute, which regulates the insurance industry, mandating accountability on the part of all insurance companies for any frivolous or unfounded refusal to provide coverage in accordance with an applicable insurance policy.

2. The state has an interest in enforcement, as this law neutrally regulates insurance claims and the Pennsylvania legislature pays subsidy to Defendants for health insurance.

3. Federal courts refuse to entertain Plaintiff's 42 Pa. C.S.A. s8371 state claim.

4. State court affords a forum for Plaintiff to enforce statutory rights under this law.

Parties

5. Plaintiff DONNA SCHEIBLER is an adult individual who resides in Westmoreland County, mailing address: RD #2, Box 468, Greensburg, PA 15601.

6. Defendant(s) HIGHMARK BLUE SHIELD; and *jointly, separately, or severally*, KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue, do business in Pennsylvania and are headquartered at Fifth Avenue Place, Pittsburgh, PA 15222.

7. Plaintiff's counsel signed a Notice to Plead on the cover page of this Motion.

Pa. Rule 1035.2, 1035.3(d)
Motion for Summary Judgment

8. Defendants accepted service of Plaintiffs' Complaint October 17, 2005.

9. Defendants filed no Answer within twenty days; the pleadings are closed.

10. Plaintiffs' physicians requested coverage January 2004, which Defendants denied May 2004, after ambiguously approving related hospital expenses.

11. Plaintiff William Scheibler relied on Defendants' approval of pre-op hyperbaric oxygen treatments,

traveling to forty miles to a hospital, four weeks in March 2004.

12. Defendants denied coverage for office surgery, as dental not medical, then requested and accepted state reimbursement in excess of costs paid by Plaintiffs, who filed suit in December 2004; Count I ERISA and Count II Bad Faith (Exhibit **A**).

13. Defendant Highmark moved for dismissal of the bad faith claim based on Pre-emption (Exhibit **B**); then filed an Answer (Ex. **C**) non-responsive to Bad Faith allegations, denying it is an ERISA insurer, based on a contract which it did not attach.

14. Plaintiffs were prejudiced by federal courts' refusal to hear the state bad faith claim; and by Defendants failure to Answer bad faith allegations of both Complaints.

15. Plaintiffs' Complaint was filed October 4, 2005.

16. Defendants' accepted service of the Complaint on October 17, 2005.

17. Twenty days have lapsed and Defendants filed no Answer.

18. Twenty days having lapsed, the pleadings are closed.

19. Plaintiff herein files a Motion for Summary Judgment; and a supporting Brief.

20. Plaintiff requests Oral Argument on the Motion, Pursuant to local rule 1035.2(c).

WHEREFORE, Plaintiffs' filed a Complaint on October 4, 2005 and Defendants accepted Sheriff Service of the Complaint October 17, 2005; twenty days have lapsed and no Answer filed, the pleadings are closed. Plaintiff herein files a Motion for Summary Judgment and a supporting Brief, requesting Oral Argument *on the Motion,* pursuant to local rule of procedure 1035.2(c), in conformity rules 1035.2 and 1035.3(d) of the Pennsylvania rules of procedure.

Respectfully submitted,

/s/Mary Ellen Chajkowski, Esquire
Counsel for the Plaintiffs

November 9, 2005

IN THE COURT OF COMMON PLEAS OF WESTMORELAND COUNTY, PENNSYLVANIA

DONNA SCHEIBLER,
Plaintiff,
vs.

HIGHMARK BLUE SHIELD; and jointly, separately, or severally,
KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue,
Defendant(s).

PLAINTIFF'S BRIEF SUPPORTING THE MOTION FOR SUMMARY JUDGMENT

AND NOW, comes the Plaintiff, Donna Scheibler, by and through her attorney, Mary Ellen Chajkowski, Esquire, and files the following brief supporting Plaintiffs' Motion for Summary Judgment against Highmark Blue Shield; and jointly, separately or severally, Keystone Health Plan West, d/b/a Security Blue, and represents the following in support:

Jurisdiction - 42 Pa. C.S.A. s 8371

This action is brought under, and jurisdiction is vested in this Court through 42 Pa. C.S.A. s 8371, the Pennsylvania Bad Faith Statute, which regulates the insurance industry, mandating accountability on the part of insurance companies for any frivolous or unfounded refusal to provide coverage in accord with applicable policy of insurance.

Standards Applicable to the Parties

Plaintiff is a statutory 'protected person' subject to strict scrutiny for enforcement of Pennsylvania's 'bad faith' insurance law. Defendants are subject to a heightened arbitrary and capricious review here, as insurers. Defendants are fiduciary entities by statute and decision makers as contemplated in Pinto v. Reliance Standard Life Ins. Co.,

214 F. 3d 377,378 (3d Cir. 2000), where this appeal court held insurers to a standard of review commensurate with their duty: "when a [an insurance] company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review. Id.

Plaintiffs' Opportunity to Be Heard

Under the Fourteenth Amendment, due process mandates that once a state has created rights or benefits, these benefits may not be stripped away without due process of law. Fuentes v. Shevin, 407 U.S. 67, 81 (1972). Plaintiff has a statutory right to be heard on the 'bad faith' claim. Without an opportunity to be heard, Defendants are unjustly enriched at Plaintiffs expense.

> The constitutional right to be heard is a basic aspect of the duty of government to follow a fair process of decision-making when it acts to deprive a person of his possessions. The purpose of this requirement is not only to ensure abstract fair play to the individual. Its purpose, more particularly, is to protect his use and possession of property from arbitrary encroachment-to minimize substantively unfair or mistaken deprivations of property, a danger that is especially great when the State seizes goods simply upon the application of and for the benefit of a private party. So viewed, the prohibition against the deprivation of property without due process of law reflects the high value, embedded in our constitutional and political history, that we place on a person's right to enjoy what is his, free of governmental interference. Id.

Defendants' Waiver Strategy

Defendants knowingly waived its opportunity to litigate Plaintiff's bad faith claim in federal court, creating an undue economic prejudice to Plaintiff, which the state court has jurisdiction and a constitutional duty to correct.

"Procedural due process rules are meant to protect persons not from deprivation, but from mistaken or

unjustified deprivation of life, liberty or property." U.S.C.A. Const. Amend. 14. Carey v. Piphus, 435 U.S. 247 (1978) *citing* Boddie v. Connecticut, 401 U.S. 371, 375 (1971). "The right to procedural due process is 'absolute' in the sense that it does not depend upon the merits of a claimant's substantive assertions, and because of the importance to organized society that procedural due process be observed, we believe that the denial of procedural due process should be actionable without proof of actual injury." Id. Defendants' waiver strategy and failure to litigate or resolve this claim is further evidence of statutory bad faith.

Respectfully submitted,
/s/Mary Ellen Chajkowski, Esquire
Filed on behalf of Plaintiff
November 9, 2005

No. 05- _____

In The

Supreme Court of the United States

DONNA SCHEIBLER, and
WILLIAM SCHEIBLER, her husband,
Insured Plaintiff,
Petitioner,

v.

HIGHMARK BLUE SHIELD,
Insurer, defendant,

THOMAS J. HARDIMAN,
United States District Court Judge,

Respondents.

On Petition for *Writ of Certiorari* to the
United States Court of Appeals for the Third Circuit

Appendix III – Respondent Pleadings

Mary Ellen Chajkowski, Esquire
Petitioner's Counsel of Record
Pennsylvania ID# 86611
5510 Hobart Street
Pittsburgh, PA 15217
412-904-2222

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Appendix III – Respondent Pleadings

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM SCHEIBLER, her husband,	
Plaintiffs,	No. 04-1928
v.	Judge Hardiman
HIGHMARK BLUE SHIELD, Defendant.	

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DEFENDANT'S MOTION TO DISMISS

NOW COMES Defendant Highmark Blue Shield ("Highmark"), by its attorneys, Gerri L. Sperling, Brian P. Fagan and Springer Bush & Perry P.C., and hereby moves this Honorable Court to dismiss Count II of Plaintiffs' Complaint pursuant to Fed.R.Civ.P. 12(b)(6) for failure to state a claim upon which relief can be granted, and in support hereof, Highmark sets forth the following:

I. PRELIMINARY AVERMENTS

1. Plaintiffs commenced this action by filing a Complaint in Civil Action (the "Complaint"), on December 23, 2004.

2. Highmark was served with a copy of the Complaint on January 3, 2005.

3. Plaintiffs allege in the Complaint that Plaintiff Donna Scheibler is an employee of ABB, Inc. ("ABB") and that she is enrolled as a beneficiary of ABB's health care benefits plan

(the "Plan"). Plaintiffs further allege that her husband, Plaintiff William Scheibler ("William") is also entitled to benefits under the Plan. (Complaint, ¶4).

4. Plaintiffs allege that "[a]t all times relevant hereto, [Highmark] provided health care insurance pursuant to an employee benefit plan on behalf of the Plaintiff, Donna Scheibler." (Complaint, ¶7).

5. Plaintiffs allege that William was diagnosed with cancer for which he underwent radiation treatment in 1997. (Complaint, ¶8). William's treating physician indicated that oral surgery was medically necessary to treat William's "radiation induced caries" condition, as a result of the radiation treatments administered for his cancer. (Complaint, ¶ 9).

6. Plaintiffs claim that Highmark approved pre- and post-operative hyperbaric oxygen treatments to be performed in anticipation of William's oral surgery, but denied payment for the surgery itself. (Complaint, ¶¶10, 11).

7. Plaintiffs appealed Highmark's denial of coverage, allegedly exhausting all administrative appeals. (Complaint, ¶¶14, 19).

8. William proceeded with his scheduled surgery, negotiating a payment to the hospital that was far less than the actual billed charges set forth on later billing statements. (Complaint, ¶16).

9. Plaintiffs claim that Highmark "may have benefited by denying coverage to [William], for payment of his hospital costs and later accepting reimbursement in excess of the agreed upon payment actually made." (Complaint, ¶17).

10. Plaintiffs seek to recover from Highmark damages that they allegedly suffered as a result of Highmark's denial of benefits under the Plan to cover the costs of William's surgery. Plaintiff' Complaint sets forth two causes of action in the following Counts:

Count I - Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1132(a)(1(B).

Count II – Pennsylvania Bad Faith Statute, 42 Pa.C.S.A. § 8371.

II. MOTION TO DISMISS PURSUANT TO FED.R.CIV.P. 12(b)(6)

11. Plaintiffs' cause of action for bad faith pursuant to Pennsylvania's Bad Faith statute, 42 Pa.C.S.A. §8371, is completely and expressly preempted by §§ 502(a) and 514(a) of ERISA, 29 U.S.C. §§ 1132(a) and 1144(a).

WHEREFORE, Defendant Highmark Blue Shield respectfully requests that this Court enter an Order dismissing Count II of Plaintiffs' Complaint.

Respectfully submitted,

Gerri L. Sperling
Pa. I.D. No. 34603

Brian P. Fagan
Pa. I.D. No. 72203

SPRINGER BUSH & PERRY P.C.
Firm No. 271
Two Gateway Center, 15th Floor
Pittsburgh, PA 15222-1402

412-281-4900

Attorneys for Defendant Highmark Blue Shield

Dated: 1/13/05

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM SCHEIBLER, her husband, Plaintiffs, v. HIGHMARK BLUE SHIELD, Defendant.	No. 04-1928 Judge Hardiman

DEFENDANT'S BRIEF IN SUPPORT OF MOTION TO DISMISS

I. PRELIMINARY AVERMENTS

Plaintiffs commenced this action by filing a Complaint in Civil Action (the "Complaint"), on December 23, 2004. Highmark was served with a copy of the Complaint on January 3, 2005.

Plaintiffs allege in the Complaint that Plaintiff Donna Scheibler is an employee of ABB, Inc. ("ABB") and that she is enrolled as a beneficiary of ABB's health care benefits plan (the "Plan"). Plaintiffs further allege that her husband, Plaintiff William Scheibler ("William") is also entitled to benefits under the Plan. (Complaint, ¶4). Plaintiffs allege that "[a]t all times relevant hereto, [Highmark] provided health care insurance pursuant to an employee benefit plan on behalf of the Plaintiff, Donna Scheibler." (Complaint, ¶7).

Plaintiffs allege that William was diagnosed with cancer for which he underwent radiation treatment in 1997. (Complaint, ¶8). William's treating physician indicated that oral surgery was medically necessary to treat William's "radiation induced caries" condition, as a result of the

radiation treatments administered for his cancer. (Complaint, & 9). Plaintiffs claim that Highmark approved pre- and post-operative hyperbaric oxygen treatments to be performed in anticipation of William's oral surgery, but denied payment for the surgery itself. (Complaint, ¶¶10, 11).

Plaintiffs appealed Highmark's denial of coverage, allegedly exhausting all administrative appeals. (Complaint, ¶¶14, 19). William proceeded with his scheduled surgery, negotiating a payment to the hospital that was far less than the actual billed charges set forth on later billing statements. (Complaint, ¶16). Plaintiffs claim that Highmark "may have benefited by denying coverage to [William], for payment of his hospital costs and later accepting reimbursement in excess of the agreed upon payment actually made." (Complaint, ¶17). Plaintiffs seek to recover from Highmark damages that they allegedly suffered as a result of Highmark's denial of benefits under the Plan to cover the costs of William's surgery. Plaintiffs' Complaint sets forth two causes of action in the following Counts:

Count I - Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1132(a)(1(B).

Count II – Pennsylvania Bad Faith Statute, 42 Pa.C.S.A. § 8371.

Concurrently herewith, Highmark has filed a Motion to Dismiss Count II of Plaintiffs' Complaint. In its Motion to Dismiss, Highmark seeks dismissal of the Complaint under Fed.R.Civ.P. 12(b)(6) because the state law claim set forth therein is completely and/or expressly preempted by ERISA. Highmark submits the instant Brief in support of its Motion to Dismiss.

II. MOTION TO DISMISS PURSUANT TO FED.R.CIV.P. 12(b)(6)

Count II of Plaintiffs' Complaint purports to state a claim pursuant to the Pennsylvania bad faith statute, 42 Pa. C.S.A. § 8371, which provides remedies for bad faith denials of insurance claims.

Recently, the Third Circuit in *Barber v. Unum Life Ins. Co. of America*, 383 F.3d 134, (3rd Cir. 2004), determined that Pennsylvania's bad faith statute is both conflict and expressly preempted by Sections 502(a) and 514(a) of ERISA, respectively. The *Barber* Court explained that conflict preemption applies to a state statute "if it provides 'a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA . . . or . . . if it 'duplicates, supplements, or supplants the ERISA civil enforcement remedy'." 383 F.3d at 140 (citations omitted). The *Barber* Court determined that "42 Pa.C.S. § 8371 is such a statute because it is a state remedy that allows an ERISA plan participant to recover punitive damages for bad faith conduct by insurers, supplementing the scope of relief granted by ERISA. Accordingly, 42 Pa.C.S. § 8371 is subject to conflict preemption." *Id.* at 140-41.

Alternatively, the Third Circuit also held that Section 8371 is expressly preempted by Section 514(a) of ERISA. Section 514(a) provides that that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). A savings provision of the Act, however, excepts from pre-emption "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

In *Barber*, the Third Circuit noted that the United States Supreme Court in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003), articulated "a

two-part test which clarified that a statute 'regulates insurance' and satisfies the savings clause only if it (1) is 'specifically directed toward entities engaged in insurance' and (2) 'substantially affect[s] the risk pooling arrangement between the insurer and the insured'." *Barber*, 383 F.3d at 141, *quoting Miller*, 538 U.S. at 341-42.

As to the first prong of the *Miller* test, the Third Circuit found that Section 8371 does "regulate[] insurers' conduct by imposing industry-wide conditions on the insurance business." *Barber*, 383 F.3d at 142. The *Barber* Court concluded, however, that Section 8371 did not meet the second prong of the *Miller* test because: (1) the statute is remedial in nature and "does not affect the kinds of bargains insured and insurers may make"; (2) "claims for bad faith insurance breaches bear no relation to the risk pooled – the risk of loss the insurer agrees to bear on behalf of the insured"; and (3) "the threat that punitive damage awards may result in increased costs that could be passed on to the insured is too attenuated to be deemed to 'substantially affect' the risk pooling arrangement". *Id.* at 143-44. Consequently, Pennsylvania's bad faith statute is both conflict and expressly preempted by ERISA and Count II of the Complaint should be dismissed.

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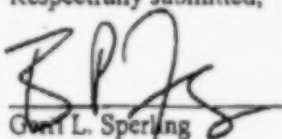
WHEREFORE, Defendant Highmark Blue Shield respectfully requests that this Court enter an Order dismissing Count II of Plaintiffs' Complaint.

Respectfully submitted,



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412-281-4900

Attorneys for Defendant Highmark Blue Shield

Dated: 4/13/05

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM SCHEIBLER, her husband,

Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

No. 04-1928

Judge Hardiman

COPY

ANSWER AND AFFIRMATIVE DEFENSES

NOW COMES Defendant Highmark Blue Shield ("Highmark"), by its attorneys, Gerri L. Sperling, Brian P. Fagan and Springer Bush & Perry P.C., and answers Plaintiff's Complaint as follows:

FIRST DEFENSE – ANSWER TO PLAINTIFF'S COMPLAINT

1. Denied as stated. Pursuant to the Court's Order dated February 1, 2005, Plaintiff's state law claim was dismissed.

2. Admitted.

3. Admitted.

4. Admitted.

5. Admitted in part. It is admitted that Plaintiff Donna Scheibler selected a health care coverage provided by Highmark (the "Plan") pursuant to a health care contract between Plaintiff's employer, ABB, Inc., and Highmark. After reasonable investigation, Highmark is without

knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in Paragraph 5 of Plaintiff's Complaint.

6. It is denied as stated that Highmark is an employee benefits plan insurer. It is admitted that Highmark maintains an address for its Member Service Department at P.O. Box 53509, Pittsburgh, PA 15253-5095.

7. Denied.

8. After reasonable investigation, Highmark is without knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in Paragraph 8 of Plaintiff's Complaint.

9. It is admitted that William Scheibler's physicians sent letters to Highmark indicating that his need for oral surgery was medically necessary. With regard to the averments set forth in Paragraph 9 of Plaintiff's Complaint which reference a letter from Dr. Rendulich to Highmark, such letter is a document which speaks for itself. Accordingly, no response to the averments as to the letter in this paragraph is required by Highmark.

10. Admitted in part. It is admitted that Highmark approved coverage for William Scheibler's Hyperbaric Oxygen treatments. After reasonable investigation, Highmark is without knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in Paragraph 10 of Plaintiff's Complaint.

11. Denied as stated. Highmark denied pre-approval of the scheduled surgery.

12. Admitted.

13. Denied.